Planned Parenthood® of Maryland, Inc.

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

Male History

Some of these questions are personal, but they help us in evaluating your health.

Reason for today's visit:_____ Age: _____

PAST MEDICAL HISTORY

Yes	No	
		Are you allergic to: ☐ latex ☐ medication (please list) _____
		Have you been under a provider's care for any illness or chronic condition? If yes what? _____
		Are you taking any medications (drugs, vitamins, over the counter medication, and herbal medication)? If yes, please list: _____

HOSPITALIZATIONS / SURGERIES

Year	Reason

SOCIAL HISTORY

Yes	No	
Nicotine, Alcohol, and/or Drug Use		
		Smoke cigarettes, cigars, pipes, or chew tobacco How much per day? _____
		Drink alcohol (beer, wine, liquor) – ____ drinks per week
		Do you or your partner use street or IV drugs?
		Do you feel like you should cut down or stop using alcohol/drugs?

Relationship & Safety

Violence and sexual abuse are common in many people's lives. There is help for you if you are being hurt or abused.
(Note: PPM is required to report cases of child abuse or neglect that occurred as a minor, even if you are now over age 18.)

My partner has threatened or frightened me.
☐ Often ☐ Sometimes ☐ Never ☐ Decline

My partner has physically abused me.
☐ Often ☐ Sometimes ☐ Never ☐ Decline

I have been forced to have sex.
☐ Often ☐ Sometimes ☐ Never ☐ Decline

FAMILY PLANNING HISTORY

Yes	No	
		Do you or your partner use birth control now? If so, what? _____ If no method, why not? ☐ trying to get pregnant ☐ partner(s) is same sex ☐ other_____
		Do you hope to have (more) children? If yes, when? ☐ More than one year ☐ Less than one year ☐ Unsure

HCA COMMENTS

_____
_____
_____
_____
_____
_____
_____ ☐ Hx reviewed
Signature:_____ Date:_____

SEXUAL HISTORY

What are you using to protect yourself from sexually transmitted infections?_____

Yes	No	
		Are you sexually active now? Check all that apply. ☐ Vaginal ☐ Anal ☐ Oral Date of last sex?_____
		Have you had a new or more than one sexual partner in the past year? Partners are: ☐ Men ☐ Women ☐ Both
		Have you ever had a sexually transmitted infection? If so, please check: ☐ Chlamydia ☐ Gonorrhea ☐ Genital Warts ☐ Hepatitis B or C ☐ Herpes ☐ HIV ☐ Syphilis ☐ Trichomoniasis ☐ Other _____
		Has your partner been treated for a sexually transmitted infection? If yes, which one? _____
		Do you have any other questions or concerns about sex that you would like to discuss today? Explain: _____

MALE GENITAL HISTORY

Yes	No	*Do you have any of the following?*
		Discharge from the penis
		Pain/swelling of the testicles/scrotum
		Pain/bleeding on ejaculation
		Sores/bumps on genitals
		Itching or irritation of genitals
		Genital trauma/ surgery. Please explain:_____
		Are you circumcised?
		Perform testicular self-exam

FILL OUT THIS SECTION IF YOU ARE UNDER 18 YEARS OLD

Yes	No	
		Are your parent(s)/guardian(s) aware of your visit to Planned Parenthood of Maryland?

CLIENT SIGNATURE

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.

X_____ Date:_____

CLINICIAN COMMENTS

_____
_____
_____
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_____
_____
_____ ☐ Hx reviewed
Signature:_____ Date:_____