

MALE MEDICAL HISTORY - Initial Visit

This medical record is confidential and will not be released to anyone without your written consent except as may be required by law. Please make the clinician aware of any questions you may have regarding the questions on this form.

Name _____ Age: _____ Date of Birth: _____ Today's Date: _____

1. Who is your family doctor or other source of medical care? _____
2. List all allergies to medicines: _____
3. List all medications that you take (prescription and over the counter, include vitamins and supplements): _____

FAMILY HEALTH HISTORY: List ONLY blood-related family members (parents, grandparents, siblings) who have had:

YES NO If yes, please explain.

- 4. I am adopted; my birth family's medical history is unknown. (If yes, skip to question 12)
- 5. Cancer of the Breast, Ovary, Uterus, Colon
- 6. Diabetes
- 7. High Cholesterol or Triglycerides
- 8. High Blood Pressure
- 9. Heart Attack or Stroke before age 50
- 10. Osteoporosis
- 11. Other: _____

PERSONAL HEALTH HISTORY: Do you have or have you ever had:

YES NO If yes, please explain.

- 12. High Blood Pressure?
- 13. Heart Disease?
- 14. HIV (Human Immunodeficiency Virus)?
- 15. Blood Transfusion/Exposure to blood?
- 16. High Cholesterol or Triglycerides?
- 17. Migraine Headaches? (frequent/severe?)
- 18. Strokes/ Blood Clots?
- 19. Seizure Disorder (Epilepsy, Convulsions?)
- 20. Anemia or Low Iron?
- 21. Gall Bladder Disease?
- 22. Anorexia, Bulimia, or other Eating Disorder?
- 23. Psychiatric / Emotional Problems, including Depression?
- 24. Urinary Tract Problems (kidney, bladder, urethra, prostate?)
- 25. Thyroid Disease?
- 26. Diabetes?
- 27. Liver Problems (Mono, Jaundice, Hepatitis)?
- 28. Tuberculosis (TB) or exposure to TB?
- 29. Cancer?
- 30. Skin allergies or irritants?

YES NO If yes, please explain.

- 31. Serious Illness/ Hospitalization / Surgery?
- 32. Eye Problems?
- 33. Birth defects / Genetic Conditions / Disabilities?
- 34. Dizziness / Numbness?
- 35. Stomach, Intestine, or Bowel Problems?
- 36. Osteoporosis?
- 37. Have you had Rubella or German Measles?
- 38. Have you been vaccinated for Hepatitis B?
- 39. Do you have a current problem with sexual abuse or domestic violence?
- 40. Do you smoke cigarettes?
How much per day? _____
For how many years? _____
- 41. Do you drink alcohol?
How much per week? _____
- 42. Do you use any other drugs?
If yes, explain: _____
- 43. Have you ever used IV drugs? _____

PLEASE TURN OVER

STAFF NOTES

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Name _____ Age: _____ Date of Birth: _____ Today's Date: _____

44. Have you ever had sex? YES NO

45. Age at first sex _____

46. Number of sexual partners in last year: _____

47. Number of sexual partners your whole life: _____

48. Have you ever tried to have a child & couldn't? _____

YES NO If yes, please explain.

49. Problems associated with sexual dysfunction?

50. Do you have *abnormal* discharge from your penis?

51. Condom use: Always Sometimes Never

52. Have you had a vasectomy? YES NO

53. Circle if you have ever had:

Gonorrhea Chlamydia Herpes

Syphilis Trichomonas Genital Warts/HPV

***Does your sex partner have a history of STIs or HIV?

Explain: _____

54. Are your sexual partners: Male Female Both

55. Sexual contact: None Vaginal Oral Anal

I acknowledge that the above information is correct and complete to the best of my knowledge.

Patient Signature: _____

Date: _____

STAFF NOTES

STAFF SIGNATURE: _____