

MALE MEDICAL HISTORY - Annual 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): _____

4. Are you using condoms when you have sex? _____ Never _____ Sometimes _____ Always

5. How many partners have you had in the last year? _____

YES NO

6. Has there been any heart disease, stroke, diabetes, or cancer in your family in the last year?

If yes, please list: _____

7. Have there been any changes in YOUR health since your visit? (new illnesses or treatments etc.)

If yes, please list: _____

8. Have you been treated for a sexually transmitted infection since your last exam here?

9. Do you smoke cigarettes? If yes, amount per day? _____

10. Do you drink alcohol? If yes, how often/how much? _____

11. Do you or your partner use other drugs? If so, what? _____

12. Are you experiencing problems with domestic violence or sexual abuse/coercion? _____

13. Do you have any problems today? Please explain: _____

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

Patient Signature: _____

Date: _____

STAFF NOTES

STAFF SIGNATURE: _____