

PLACE PT LABEL HERE

MALE MEDICAL HISTORY / REVIEW OF SYSTEMS

Name _____

Date: / / Age: _____

PERSONAL HISTORY	YES	NO
1. Are you being treated for any illness/condition now? If yes, what?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you smoke cigarettes? If yes, how many per day?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you drink alcohol? If yes, how often?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use street drugs? If yes, what?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use over-the-counter drugs? If yes, what?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you take prescription drugs? If yes, what?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you feel safe in your current relationship?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have concerns about domestic violence?	<input type="checkbox"/>	<input type="checkbox"/>
9. Is anyone forcing you to have sex?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		
SEXUAL HISTORY	YES	NO
1. Are you currently sexually active?	<input type="checkbox"/>	<input type="checkbox"/>
2. When was the last time you had sex?		
3. How many sexual partners do you currently have?		
4. How long have you been with your current partner(s):		
5. How many partners have you had in the past 12 months?		
6. Do you have sex with: () men () women () both		
7. Do you participate in (check ✓ all that apply): () oral sex () vaginal sex () anal sex () outer course		
8. At what age did you first start having sex?		
9. Do you have sexual concerns?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		
HEMATOLOGICAL / LYMPHATIC	YES	NO
1. Do you have liver disease, hepatitis or gall bladder disease?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a blood clotting disorder?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a history of cancer?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		
RESPIRATORY	YES	NO
1. Do you have lung disease (asthma, TB)?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		

CARDIOVASCULAR – Do you have or have you ever had:	YES	NO
1. Varicose veins/phlebitis?	<input type="checkbox"/>	<input type="checkbox"/>
2. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
3. High cholesterol or fats?	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart disease, heart surgery, or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
5. Stroke or stroke-like symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		
GASTROINTESTINAL – Do you have or have you ever had:	YES	NO
1. Stomach problems, bowel problems, or ulcers?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		
MUSCULOSKELETAL	YES	NO
1. Do you ever have swollen/painful joints?	<input type="checkbox"/>	<input type="checkbox"/>
2. How many times have you broken a bone?		
3. Do you have any sensory difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		
NEUROLOGICAL – Do you have or have you ever had:	YES	NO
1. Migraines/severe headaches diagnosed by a Dr.?	<input type="checkbox"/>	<input type="checkbox"/>
2. Visual changes not related glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
3. Fainting when your blood is drawn?	<input type="checkbox"/>	<input type="checkbox"/>
4. Seizure disorder/epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		
ENDOCRINE	YES	NO
1. Do you have night sweats/ hot flashes?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have diabetes/	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		
ALLERGY / IMMUNOLOGY	YES	NO
1. Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you up to date with your rubella vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		

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MALE MEDICAL HISTORY / REVIEW OF SYSTEMS

FAMILY HISTORY	MOTHER	FATHER	BROTHER	SISTER	
Family history not available <input type="checkbox"/>					
Has your biological family (mother, father, brother, sister) had any of the following (circle all that apply):					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke before age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease before 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High cholesterol or fats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STAFF COMMENTS:					
BIRTH CONTROL				YES	NO
1. Are you currently using a birth control method?				<input type="checkbox"/>	<input type="checkbox"/>
If yes, what?					
2. What birth control method does your partner(s) use?					
STAFF COMMENTS:					

GENITOURINARY – Do you have or have you ever had:	YES	NO
1. Urinary tract, bladder, kidney infections or diseases?	<input type="checkbox"/>	<input type="checkbox"/>
2. Pain or bleeding with sex?	<input type="checkbox"/>	<input type="checkbox"/>
3. Any of the following (check ✓ all that apply):		
<input type="checkbox"/> chlamydia <input type="checkbox"/> gonorrhea <input type="checkbox"/> genital warts		
<input type="checkbox"/> herpes <input type="checkbox"/> syphilis <input type="checkbox"/> HIV		
4. Severe scrotal injury?	<input type="checkbox"/>	<input type="checkbox"/>
5. Fluid pocket inside scrotum (hydrocele)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Hernia?	<input type="checkbox"/>	<input type="checkbox"/>
7. Undescended testicle?	<input type="checkbox"/>	<input type="checkbox"/>
8. Infection of the reproductive tract, testes, epididymis, vas deferens or prostate?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		
PSYCHOLOGICAL	YES	NO
1. Do you have depression, mental illness, or anxiety disorder?	<input type="checkbox"/>	<input type="checkbox"/>
STAFF COMMENTS:		

I give the above information freely. It is complete and correct to the best of my knowledge. I understand that it is for Planned Parenthood's use only and will not be released to anyone else without my written permission unless ordered to do so by court order.

Patient Signature: _____

Date: _____

Medical Provider Signature: _____

Date: _____