Planned Parenthood®
of Western Washington

Male Self-Medical History

Today's Date____________

Name ______________________________ Age ______ Occupation ____________________

Reason for today's visit? ______________________________

Contraception

What method does your partner use to prevent pregnancy?

____

Do you support her use of this method? ☐ yes ☐ no

Yes	No	
☐	☐	Do you use condoms consistently
☐	☐	Have you had unprotected intercourse in the past month?
☐	☐	Do you know about emergency contraception?
☐	☐	Are there any problems with birth control or STD prevention for you or your partner?

Pregnancy

Yes	No	
☐	☐	Do you have biological children? How many?_____
☐	☐	Do you want to have any more biological children?
☐	☐	Is your partner currently trying to become pregnant? If yes, for how long? ________________

Safety

Yes	No	
☐	☐	Do you use seatbelts?
☐	☐	Do you use a bicycle or motorcycle helmet?
☐	☐	Do you have guns in your home?

If yes, are they locked up? ☐ Yes ☐ No

Sexual History

Yes	No	
		Age of 1st intercourse: ______________
☐	☐	Have you had sexual intercourse?
☐	☐	Are you currently in a sexual relationship?
☐	☐	New sex partner in last 60 days?
☐	☐	2 or more partners in the last 60 days?
☐	☐	Partner with symptoms in last 60 days?
☐	☐	Have you had chlamydia in last 12 months?
☐	☐	Do you have sex for drugs or money?
☐	☐	Have you ever been tested for HIV? If yes, when? ________________________

Are your partner(s) ☐ Male ☐ Female ☐ Both

How many sexual partners have you had:

In the past year? __________ In your lifetime? __________

How do you protect yourself from STDs? ______________

Social History

Yes	No	
☐	☐	Do you smoke? If so, how many cigarettes/day and for how long? ____________________
☐	☐	Do you drink alcohol? If so, how often/how much? ____________________
☐	☐	Do you or your partner use street or IV drugs? If so, what ____________________
☐	☐	Do you exercise regularly?
☐	☐	Do you have concerns about your weight or eating habits that you would like to discuss today?

Planned Parenthood can help women and men who have concerns about sexuality, or have had a history of sexual assault, rape (including date-rape), physical abuse, domestic violence (including between unmarried partners as well as same-sex partners), addictions, or emotional/mental health difficulties. We can also help if you are currently in a situation where any of these are occurring, have recently occurred, or are of immediate concern to you.

☐ yes ☐ no Are you now experiencing or have concerns about domestic violence or any of the above mentioned issues?

For Clinicians Only:

☐ yes ☐ no Client was queried about all the above

☐ yes ☐ no Client was given relevant educational materials and referral information.

Place label here
Include name, number and DOB

Clinician Reviews:

Signature: ________________________ Date: ___ /___ /___

Signature: ________________________ Date: ___ /___ /___

Signature: ________________________ Date: ___ /___ /___

Past Medical History

ALLERGIES TO MEDICATION ☐ yes ☐ no What medications? ____________________

Do you have a latex allergy? ☐ yes ☐ no Other allergies (shellfish, etc) ____________________

Have you ever had surgery, been a patient in a hospital or had a major illness? ☐ yes ☐ no

If yes, explain ____________________

List all medications you take ____________________

Where else do you go for healthcare? ____________________

When and where was your last physical exam? ____________________

Have you had the following immunizations: Hep B series ☐ yes ☐ no Tetanus ☐ yes ☐ no Rubella ☐ yes ☐ no

Have you ever had a blood transfusion? ☐ yes ☐ no If yes, when? ____________________

Please review the following list. Let us know your past health history and what symptoms you have TODAY:

Review of Systems

Now	In Past	Never	
			GENERAL
☐	☐	☐	My health is generally good
☐	☐	☐	Recent 25+ pound weight gain or loss
☐	☐	☐	Night sweats/hot flashes
☐	☐	☐	Fever, chills
☐	☐	☐	Cancer
			SKIN
☐	☐	☐	Rash, bumps, sores
☐	☐	☐	Other skin problems
☐	☐	☐	Acne
			EYES
☐	☐	☐	Visual changes (except contacts/glasses)
			EARS, NOSE, THROAT
☐	☐	☐	Hearing problems
☐	☐	☐	Frequent nosebleeds
☐	☐	☐	Frequent sore throat
☐	☐	☐	Nasal polyps
			ENDOCRINE
☐	☐	☐	Diabetes
☐	☐	☐	Thyroid problems
			NEUROLOGIC
☐	☐	☐	Severe headaches
☐	☐	☐	Persistent numbness, tingling
☐	☐	☐	Fainting
☐	☐	☐	Diagnosed migraines
☐	☐	☐	Epilepsy/seizures
☐	☐	☐	Stroke

Now	In Past	Never	
			CARDIOVASCULAR
☐	☐	☐	Palpitations/heart murmur
☐	☐	☐	Heart disease
☐	☐	☐	High blood pressure
☐	☐	☐	Blood clots in veins or lungs
☐	☐	☐	High cholesterol
☐	☐	☐	Anemia or bleeding disorder
			BREASTS
☐	☐	☐	Mass or lump
☐	☐	☐	Discharge, tenderness
			RESPIRATORY
☐	☐	☐	Chronic cough
☐	☐	☐	Breathing problems
☐	☐	☐	Asthma
☐	☐	☐	Tuberculosis
			GASTROINTESTINAL
☐	☐	☐	Diarrhea
☐	☐	☐	Constipation
☐	☐	☐	Irritable bowel syndrome
☐	☐	☐	Colitis
☐	☐	☐	Gall bladder disease
☐	☐	☐	Liver disease/hepatitis Type ____________
☐	☐	☐	Eating disorder
☐	☐	☐	Stomach ulcer
☐	☐	☐	Bleeding from rectum
			MUSCULOSKELETAL
☐	☐	☐	Joint or muscle pain
☐	☐	☐	Back pain

Now	In Past	Never	
			GENITOURINARY
☐	☐	☐	Discharge from your penis
☐	☐	☐	Genital itching or burning
☐	☐	☐	Genital rash, bumps, sores
☐	☐	☐	Pain during or after ejaculation
☐	☐	☐	Pain or burning with urination
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Bladder disease
☐	☐	☐	Kidney disease
☐	☐	☐	Pain in abdomen
☐	☐	☐	Pain in testicles
☐	☐	☐	Genital warts
☐	☐	☐	Chlamydia
☐	☐	☐	Gonorrhea
☐	☐	☐	Herpes Type 1
☐	☐	☐	Herpes Type 2
☐	☐	☐	Syphillis
☐	☐	☐	Trichomoniasis
☐	☐	☐	Hernia
☐	☐	☐	Groin injury
☐	☐	☐	Prostate disease
☐	☐	☐	Jock itch
☐	☐	☐	Abnormalities of reproductive organs

How long since you last urinated? ________

Now	In Past	Never	
			PSYCHOLOGICAL
☐	☐	☐	Depression
☐	☐	☐	Anxiety/mood swings
☐	☐	☐	Under psychiatric care

Immediate Family History: Do your mother, father, sister or brother have the following? Please check each item.

Yes	No	Don't Know	
☐	☐	☐	Are you adopted? ____________
☐	☐	☐	Testicular cancer? ____________
☐	☐	☐	Diabetes? ____________
☐	☐	☐	Heart attack/stroke/blood clots? ____________
☐	☐	☐	High blood pressure? ____________
☐	☐	☐	TB (Tuberculosis)? ____________

Yes	No	Don't Know	
☐	☐	☐	High cholesterol? ____________
☐	☐	☐	History of inheritable disease? ____________ (Tay-Sachs, sickle cell anemia, etc.)
☐	☐	☐	Prostate cancer ____________

Place label here
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Client Signature ____________________