



MALE MEDICAL HISTORY

Your records are considered confidential. Planned Parenthood will call or write only if we need to contact you regarding test results that are not normal, or for emergency purposes.

PATIENT LABEL

AGE _____ ALLERGIES _____ DATE COMPLETED _____

REVIEW OF SYSTEMS

HAVE YOU EVER HAD:

GENERAL

YES NO

- 1. Eating disorder
- 2. Frequent colds/flu, etc.
- 3. Chronic fatigue
- 4. Cancer
- 5. My health is good

SKIN

YES NO

- 6. Acne/other skin problems
- 7. Chronic rash, itching

EYES

YES NO

- 8. Eye problems/visual problems
- 9. Do you wear glasses/contacts?

EARS, NOSE, THROAT, MOUTH

YES NO

- 10. Hearing problems
- 11. Teeth/gum problems
- 12. Frequent nosebleeds
- 13. Frequent sore throats

RESPIRATORY

YES NO

- 14. Asthma/Lung disease/TB
- 15. Persistent shortness of breath

CARDIOVASCULAR

YES NO

- 16. Heart disease/Murmur/Stroke
- 17. High blood pressure
- 18. High cholesterol/Triglycerides
- 19. Thrombophlebitis/Blood clots in veins/lungs
- 20. Lupus Erythematosus

GASTROINTESTINAL

YES NO

- 21. Stomach/Bowel problems
- 22. Liver disease/Hepatitis
- 23. Gall bladder disease

GENITOURINARY

YES NO

- 24. Bladder/kidney problems
- 25. Injuries to testicles or groin
- 26. Chlamydia
- Gonorrhea
- Herpes
- Syphilis
- Genital Warts
- HIV
- Hernia/Hydrocele/Varicocele
- 27. Breast disease/Lump/Tumor/Surgery

NEUROLOGIC

YES NO

- 28. Stroke
- 29. Migraine (diagnosis by MD)
- 30. Seizures/Epilepsy

HEMATOLOGIC

YES NO

- 31. Anemia
- 32. Blood disorder/transfusion

MUSCULOSKELETAL

YES NO

- 33. Arthritis
- 34. Broken Bones/Fractures

PSYCHOLOGY

YES NO

- 35. Depression/Mood Swings
- 36. Anxiety
- 37. Under care of Psychiatrist/
Psychologist

ENDOCRINE

YES NO

- 38. Thyroid disease
- 39. Diabetes
- 40. Persistent swollen glands

PAST MEDICAL HISTORY:

- 43. Have you ever had surgery or been a patient in a hospital? **YES explain** _____ **NO**
- 44. Are you now, or have you been, under a doctor's care for a serious illness or condition? **YES** **NO**
- 45. Do you have any drug allergies? **YES** **NO** If yes, what? _____
Local anesthesia? **YES** **NO** Are you allergic to latex? **YES** **NO** Betadine? **YES** **NO**
- 45. Have you had childhood immunizations? **YES** **NO**
- 46. Have you been immunized for Hepatitis B? **YES** **NO**
- 47. Please list any drugs you are taking now, including over-the-counter medications, herbal medications, and vitamins. _____

48. Date of last physical exam _____

FOR CLINICIAN / RN USE ONLY

