

MALE HISTORY

TO BE COMPLETED BY PATIENT

HEALTH HISTORY

Y	N	?		List/Comments
			Generally healthy?	
			Are you currently taking any medications? (Specify)	
			Allergic to any medications, foods, &/or other substances?	
			Vaccinated for Hepatitis B? Series completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
			Vaccinated for Hepatitis A? Series completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	
			Any tattoos?	
			Any piercings?	
			Drink alcohol; if yes, _____ per day/ week	
			Social/street drugs; If yes type: _____ per day/week	
			Smoke cigarettes? If yes, # per day: _____ How long?	
			Other tobacco products? If yes, amount per day: _____ How long?	
			Do you examine your testicles? If yes, how often?	
			Did your mother take DES when she was pregnant with you?	
			Sexual abuse in the past? At what age?	
			Emotional/relationship problems?	

SEXUAL HISTORY

How many sex partners in last year? _____	In past month? _____
Sexual contact: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Anal	
Are you or your partner(s) currently using a method of birth control or STD protection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sexually active	
If yes, what do you use?	
Do you use condoms during sexual contact: <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never	
If you do not <u>always</u> use condoms, when was your last unprotected sexual contact?	

INFECTION HISTORY: Do you now have or have you ever had:

Y	N	?	Comments	Y	N	?	Comments
			Chlamydia				Trichomoniasis
			Genital Warts				Hepatitis A
			Gonorrhea				Hepatitis B
			Herpes				Hepatitis C
			Syphilis				HIV

SYMPTOMS: Do you currently have:

Y	N	?		Y	N	?	
			Burning upon urination				Swollen glands
			Discharge from penis				Mouth sores
			Pain in your testicles				Sores, bumps, or rash in genital area
			Lower abdominal/groin pain				Current partner having symptoms of an STD?
			Rectal pain/discharge				Partner recently treated for an STD?

DATE STAFF COMMENTS

I have answered and reviewed all of the questions on this form to the best of my knowledge.

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____

Name: _____

Chart #: _____ DOB: _____ Age: _____ Date: _____