

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

ANNUAL/REVISIT HISTORY / MALE On-Line

Date: _____

Name: _____ SS# _____ Date of Birth: _____ Age: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Can we write / call you identifying ourselves as Planned Parenthood? [] Yes [] No. If answer is no, you will be contacted by "MAX".

Emergency Contact _____ Phone _____ Address _____

Relationship _____

Do you have a job? ___no ___yes, What is your monthly pay? _____ How many people do you support? _____

Are you a student? ___no ___yes, What grade did you last finish? _____

Do you have Medicaid or any other insurance? ___no ___yes Please write name _____

Are you allergic to any medications? ___no ___yes, please list _____

Reason for today's visit: _____

Y e s	N o	Medical History Are you experiencing?	Staff Use Only	Y e s	N o	Current Health Practices Do You
		1. Unusual discharge from the penis?				12. Smoke cigarettes: Amount/day _____
		2. Pain, burning or difficulty with urination?				13. Use alcohol: Amount/week _____
		3. Frequent urination or blood in urine?				14. Use street drugs: Type _____
		4. Pain or bleeding with sex or ejaculation?				SINCE YOUR LAST VISIT HAVE YOU HAD:
		5. Rectal pain, bleeding or discharge?				15. Illness, surgery, hospitalization
		6. Bumps or sores on your penis or genital area?				16. Jaundice (yellow skin or eyes), hepatitis, mononucleosis
		7. Have you recently taken antibiotics for infection?				17. Any changes in the health of close family members? (heart attack, stroke, diabetes, cancer, cholesterol, death)
		8. Have you or your partner had more than one sexual partner in the past three months?				18. Are you allegeric to any medicine? What: _____
		9. Has your partner(s) had bumps, sores or discharge in genital area?				19. Are you in pain today? Please circle re: severity 0 1-2 3-4 5-6 7-8 9-10
		10. Has your partner recently been treated for a sexually transmitted disease?				
		11. Are you using condoms for every sex act?				Location of today's pain _____

Please list all medications or drugs you are using now or take frequently, including over-the-counter medications, herbs and vitamins _____

To the best of my knowledge, the above information is complete and accurate

Client signature: _____

Date: _____