

MALE HISTORY FORM

Date _____ / _____ / _____

Patient Name _____ DOB _____ Patient ID# _____ AGE _____

Personal Medical History

Have you ever had any of the following conditions?

Please check all that apply

- Stroke Yes No
- Heart Attack Yes No
- High Blood Pressure Yes No
- Headaches Yes No
- Eye Problems Yes No
- Dizziness/Fainting Yes No
- Anemia Yes No
- Blood Clotting Disorder/
Blood transfusion or exposure Yes No
to blood products
- Varicose Veins/Inflamed Veins Yes No
(Thrombophlebitis)
- High Blood Fat Yes No
(Cholesterol / Triglycerides)
- Heart Problems Yes No
(Murmurs, Rheumatic Fever/Valve, etc.)
- Kidney Disease Yes No
- Chronic Bladder Infection Yes No
- Sexually Transmitted Infections Yes No
(herpes, gonorrhea, syphilis, trich,
condyloma/warts, chlamydia, hepatitis B/C)
- Have you ever been diagnosed Yes No
with HIV/AIDS?
- Cancer Yes No
Type: _____
- Liver Problems Yes No
(Mononucleosis / Hepatitis B/C)
- Gastrointestinal Problems Yes No
- Lung Problems Yes No
(shortness of breath, asthma)
- Positive Tuberculosis Test Yes No
- Gall Bladder Problems Yes No
(stone or removal)
- Sensory difficulties Yes No
(ie: numbness)
- Diabetes/Sugar in Urine Yes No
- Epilepsy/Seizures Yes No
- Genetic Abnormalities Yes No
Kind: _____
- Thyroid Problems Yes No
- Substance Abuse Yes No
Type: _____

Allergies: Drug/skin _____

Current Medication/MV/Supplements: _____

- Depression/suicidal thoughts Yes No
- Sickle Cell Disease/Trait Yes No
- Leg, Chest, Arm or Abdominal Pain Yes No

Do you need to update your immunizations? Yes No

- Tetanus Yes No
- TB Yes No
- Rubella Yes No
- Flu Yes No
- Hepatitis Yes No
- Mumps Yes No
- I was adopted Yes No
- Smoke Yes No
Pack per Day _____

Did your mother take DES (drug to prevent miscarriage) during her pregnancy with you? Yes No

Are you receiving treatment from another source of medical care at this time? Yes No

Who? _____

Date of visit: _____

Reason for treatment: _____

Major Surgeries: _____

Hospitalization: _____

Current Health Needs

Year of last physical exam _____

Was everything normal? Yes No

Any other significant medical/health information?

Are there any areas of health or well being you would like to discuss?

Family Medical

Mother, Father, Brother, Sister

- Stroke Yes No
- Heart Attack Yes No
What Age: _____
- High Blood Pressure Yes No
- Cancer Yes No
Type: _____
- Diabetes Yes No
- Sickle Cell Disease/Trait Yes No
- High Blood Fats Yes No
(Cholesterol / Triglycerides)

Reproductive History

Do you examine your testicles regularly? Yes No

Have you ever had sores, lumps, or growths on your penis or testicles or scrotum? Yes No

Do you have a discharge from your penis? Yes No

Have you ever had an infection, injury, or surgery on your penis, testicles, or scrotum? Yes No

Do you have any unusual genital itching? Yes No

Do you have any pain, bleeding or other problems with intercourse or ejaculations? Yes No

MEDICAL HISTORY CHANGES / NOTES

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Sexual History

Current pattern of sexual activity:
 vaginal anal oral outercourse none
Sexual Partners:
 Male Female Both
Age at first intercourse: _____
More than one sex partner in last year or change in partner? Yes No
Does your partner have signs of infection?
 Yes No
Request testing for sexually transmitted infections
 Yes No
Emotional/relationship problems you would like to discuss?
 Yes No

Social History

Number of children: _____
Ages: _____
Occupational hazards or environmental toxin exposure? Yes No
Have you ever been hit, slapped, kicked or otherwise hurt by someone? Yes No
Has anyone ever forced you to have sex? Yes No
Afraid of your partner(s) or others? Yes No
If you are under eighteen (18) and answered yes, we are required to report abuse to the proper authorities
Sexual partner history: Uses injectable drugs Yes No
Has multiple partners Yes No
Bisexual Yes No

Contraceptive History

Please check all birth control methods you or your partner have used:

- Abstinence
- Condoms
- Foam, Cream, Insert
- Fertility Awareness
- Withdrawal
- Sponge
- IUD
- Pills
- Patch (Evra)
- Depo Provera
- Vaginal Ring
- Sterilization
- Diaphragm
- Other
- Kind: _____
- None

What birth control method are you currently using? _____
Do you wish to continue your current method? _____
If not what method do you wish to discuss? _____

Health Habits

(Check or fill in blanks to all that apply)
Occupation: _____
Yes No
 Exercise (type): _____
 Street drugs (type): _____
 Drink alcohol # of drinks per week? _____
 Smoke cigarettes # of cigarettes per day? _____
 Does alcohol and/or drugs cause a problem in your life?
 Exposed to chemical hazards at place of employment?
 Wear seat belts

To the best of my knowledge the information I have provided is correct and complete.

Patient Signature _____ Date _____

Initial History Reviewed By:

Clinician Signature _____ Date _____