# MALE MEDICAL HISTORY

Patient Name _____ Date _____ Age _____

MRN _____ Clinic Name _____ Date of Birth _____

## ALLERGIES

Are you allergic to any drug or medication, including anesthesia? ❑ No ❑ Yes

Are you allergic to Latex? ❑ No ❑ Yes Are you allergic to iodine or shellfish? ❑ No ❑ Yes

If you answered yes to any of the above, please write the medication and type of reaction: _____

## MEDICATIONS

List all medications or drugs you are now taking or take often including prescription medications, over-the-counter medications, herbal medications, vitamins, minerals, or supplements: _____

## PAST MEDICAL HISTORY

Check if *you* have now or in the past have had: ❑ No past medical conditions

❑ Anemia
❑ Asthma
❑ Enlarged Prostate
❑ Stroke
❑ Chlamydia
❑ Cancer
❑ DVT/Blood Clot in Legs
❑ Depression
❑ Diabetes
❑ Drugs/Alcohol Abuse
❑ Eating Disorder
❑ Fracture
❑ Gallbladder Disease
❑ Genital Herpes
❑ Genital Warts
❑ Gonorrhea
❑ Heart Failure
❑ Hepatitis B
❑ Hepatitis C
❑ HIV/AIDS
❑ High Cholesterol
❑ High Blood Pressure
❑ Infertility
❑ Inflammatory Bowel Disease
❑ Kidney Failure
❑ Liver Disease/Tumor
❑ Lupus
❑ Migraine
❑ Heart Attack
❑ Osteoporosis
❑ Psychiatric Disorder
❑ Seizure/Epilepsy
❑ Suicide Attempt
❑ Syphilis
❑ Thyroid Disease
❑ Tuberculosis
❑ Other Medical Conditions:

## PAST SURGICAL HISTORY

Check if *you* have had any of these surgeries: ❑ Never had surgery

❑ Appendix removed
❑ Cataracts removed
❑ Gallbladder removed
❑ Surgery for Weight Loss
❑ Heart Surgery: _____
❑ Hernia Repair
❑ Liver Biopsy
❑ Prostate Biopsy
❑ Prostate Surgery
❑ Vasectomy
❑ Other: _____

## IMMUNIZATION HISTORY

Check the immunizations/vaccinations you've had:

❑ Hepatitis A
❑ Hepatitis B
❑ HPV
❑ MMR/Rubella
❑ Tetanus
❑ Varicella

## FAMILY HISTORY

If you are ADOPTED and do not know your biological family's medical history, **SKIP this section.**

Check any of your BLOOD relatives (Parents, Brothers, Sisters, Children ONLY) who have had any of the following:

- ❑ Blood Disease who: _____
- ❑ Heart Attack who: _____
- ❑ Stroke who: _____
- ❑ Cancer who: _____
  Type: _____
- ❑ Diabetes who: _____
- ❑ High Cholesterol who: _____
- ❑ High Blood Pressure who: _____
- ❑ Osteoporosis who: _____
- ❑ Renal Disease who: _____

## CONTRACEPTIVE HISTORY

Current birth control method:

- ❑ Condoms: Always/Usually/Sometimes
- ❑ Withdrawal
- ❑ Not having sex (abstinence)
- ❑ Vasectomy
- ❑ Partner using contraception
- ❑ None
- ❑ Partner can't get pregnant
- ❑ We want to get pregnant within a year

Any problems with your current method? ❑ No ❑ Yes (please explain): _____

_____

## SEXUAL HISTORY

❑ No Intercourse Yet

How many people have you had sex with in the last year? _____

Have you had sex with someone new in the last 90 days? ❑ Yes ❑ No

Do you have sex with: ❑ Men ❑ Women ❑ Both

Does the person(s) you have sex with have sex with: ❑ Men ❑ Women ❑ Both ❑ Unknown

Does the person(s) you have sex with only have sex with you? ❑ Yes ❑ No ❑ Unknown

Is your sexual contact (check all that apply): ❑ Vaginal ❑ Oral ❑ Anal ❑ Other: _____

Do you use condoms? ❑ Always ❑ Sometimes ❑ Never

Have you been exposed to a Sexually Transmitted Infection (STI) recently? ❑ No ❑ Yes: _____

Has the person(s) you have sex with had any STI symptoms in the last 60 days? ❑ Yes ❑ No ❑ Unknown

Have you ever shared needles (tattoo, IV drug use, etc.)? ❑ No ❑ Yes: _____

Have you had sex with someone who uses IV drugs? ❑ Yes ❑ No ❑ Unknown

Did you get a blood transfusion before 1985? ❑ No ❑ Yes

## SUBSTANCE USE

Have you ever used street, recreational, or IV drugs? ❑ Yes ❑ No If so, what? _____

Do you currently use street, recreational, or IV drugs? ❑ Yes ❑ No If so, what? _____

Do you smoke cigarettes? ❑ Yes ❑ No ❑ Not anymore If so, how many/how often? _____

Do you use other types of tobacco? ❑ Yes ❑ No If so, how many/how often? _____

Do you drink alcohol? ❑ Yes ❑ No If so, how often/how much? _____

Do you feel you have a problem with drugs or alcohol? ❑ Yes ❑ No Why? _____

## LIFESTYLE/CHALLENGES/SUPPORT

Any recent major life changes? ❑ Yes ❑ No If so, what? _____

Any concerns regarding weight or eating? ❑ Yes ❑ No If so, what? _____

Are you being abused sexually, physically, or emotionally? ❑ Yes ❑ No If so, how? _____

_____

Are you being forced to do something against your will? ❑ Yes ❑ No If so, what? _____

Do you have a good support system? ❑ Yes ❑ No If so, who? _____

Do you eat a healthy diet? ❑ Yes ❑ No Do you exercise regularly? ❑ Yes ❑ No

Do you work? ❑ Yes ❑ No If yes: ❑ Full Time ❑ Part Time Are you a student? ❑ Yes ❑ No

## REVIEW OF SYSTEMS

Check whether you are having any of these symptoms NOW, or VERY OFTEN:

**Constitutional**

❑ No ❑ Yes Weight gain (unexplained, more than 20 lbs. in the past year)
❑ No ❑ Yes Weight loss (unexplained, more than 20 lbs. in the past year)
❑ No ❑ Yes Fever/chills
❑ No ❑ Yes Hot Flashes
❑ No ❑ Yes Fatigue/lethargy/malaise

**Cardio/Cerebrovascular**

❑ No ❑ Yes Chest pain
❑ No ❑ Yes Palpitations/Irregular heart beat
❑ No ❑ Yes Syncope/fainting

**Gastrointestinal**

❑ No ❑ Yes Abdominal pain
❑ No ❑ Yes Constipation
❑ No ❑ Yes Diarrhea
❑ No ❑ Yes Nausea/Vomiting
❑ No ❑ Yes Rectal bleeding
❑ No ❑ Yes Bloody stool
❑ No ❑ Yes Involuntary loss of gas/stool

**Genitourinary**

❑ No ❑ Yes Painful urination/Dysuria
❑ No ❑ Yes Leaking urine/Incontinence
❑ No ❑ Yes Frequent urination
❑ No ❑ Yes Hesitancy
❑ No ❑ Yes Decreased stream
❑ No ❑ Yes Urethral discharge
❑ No ❑ Yes Flank pain
❑ No ❑ Yes Groin pain
❑ No ❑ Yes Testicle pain
❑ No ❑ Yes Quick ejaculation
❑ No ❑ Yes Erectile Dysfunction
❑ No ❑ Yes Lesions/Rash
❑ No ❑ Yes Blood in urine
❑ No ❑ Yes Incomplete emptying
❑ No ❑ Yes Urine loss when coughing or lifting

**Ears, Nose, Mouth, Throat**

❑ No ❑ Yes Hearing problems
❑ No ❑ Yes Frequent nosebleeds
❑ No ❑ Yes Tooth/gum problems
❑ No ❑ Yes Frequent sore throat
❑ No ❑ Yes Ringing in the ears
❑ No ❑ Yes Earaches
❑ No ❑ Yes Sinus Problems
❑ No ❑ Yes Mouth Sores

**Respiratory**

❑ No ❑ Yes Chronic cough
❑ No ❑ Yes Shortness of breath
❑ No ❑ Yes Difficult breathing on exertion
❑ No ❑ Yes Painful breathing
❑ No ❑ Yes Wheezing
❑ No ❑ Yes Spitting up blood

**Skin/Breast**

❑ No ❑ Yes Rash
❑ No ❑ Yes Skin lesion
❑ No ❑ Yes Breast lump
❑ No ❑ Yes Dry skin
❑ No ❑ Yes Moles (growth/changes)

**Endocrine**

❑ No ❑ Yes Alopecia (hair loss)
❑ No ❑ Yes Cold or heat intolerance
❑ No ❑ Yes Excessive hunger, thirst, or urination

**Neurologic**

❑ No ❑ Yes Headache
❑ No ❑ Yes Visual disturbance
❑ No ❑ Yes Weakness
❑ No ❑ Yes Dizziness
❑ No ❑ Yes Seizures
❑ No ❑ Yes Numbness
❑ No ❑ Yes Migraine/Aura

**Psychiatric**

❑ No ❑ Yes Little interest or pleasure in doing things
❑ No ❑ Yes Feeling down, depressed, or hopeless
❑ No ❑ Yes Feeling suicidal
❑ No ❑ Yes Seeing a therapist or psychiatrist
❑ No ❑ Yes Anxiety

**Eyes**

❑ No ❑ Yes Problems seeing not corrected by glasses/contacts
❑ No ❑ Yes Eye burning, discharge, itching or pain
❑ No ❑ Yes Vision changes
❑ No ❑ Yes Glasses/Contacts

**(Continued on next page...)**

## REVIEW OF SYSTEMS (CONTINUED)

Check whether you are having any of these symptoms NOW, or VERY OFTEN:

Allergic/Immunologic

❑ No ❑ Yes Hay fever
❑ No ❑ Yes Hives/urticaria
❑ No ❑ Yes Contact dermatitis

Musculoskeletal

❑ No ❑ Yes Back pain
❑ No ❑ Yes Myalgias (muscle aches)
❑ No ❑ Yes Muscle weakness

Hematologic/Lymphatic

❑ No ❑ Yes Easy bruising
❑ No ❑ Yes Easy bleeding
❑ No ❑ Yes Enlarged lymph nodes
❑ No ❑ Yes Cuts that do not stop bleeding

**Patient Signature:** _____ **Date:** _____