

INITIAL MALE PATIENT HISTORY MEDICAL RECORD

PERSONAL HISTORY				
HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	?	STAFF NOTES ONLY
Allergies (food, medications, latex)? List: _____				
Anemia (low blood/low iron)				
Arthritis				
Asthma/breathing problems/bronchitis/TB				
Birth Defects/Retardation What type? _____				
Bladder/Kidney problems				
Blood clots in arms/legs/chest				
Blood disease or bleeding problems				
Bone problems (brittle, weak bones)				
Bowel or stomach problems				
Breast lump/nipple discharge				
Prostate cancer				
Colon cancer				
Dental problems				
Depression/Mental Illness/Suicide attempt				
Diabetes (high sugar)				
Ear problems/ hearing problems/deafness				
Epilepsy/Seizures/Fainting spells				
Eye problems (dizziness, blurring, blackouts)				
Headaches (all the time/very bad)				
Heart problems				
Hepatitis/Liver disease				
Hepatitis B shots				
High blood pressure/stroke				
Penis/testicles/prostate pain				
Rubella(German measles)/shot for Rubella(MMR)				
Are you up-to-date on your immunizations like Hepatitis or Tetanus?				
Sexually transmitted infections: circle •Chlamydia, Gonorrhea, Herpes, HIV/AIDS, Syphilis, Genital warts, Nongonococcal urethritis (NGU), other				
Sickle cell anemia/trait				

LABEL

Skin problems				
Thyroid problems				
Varicose veins				
Any other serious medical condition, surgery, or hospitalization Date: _____				
Do you do monthly testicular exam?				
Do you take (or suppose to take) medicines prescribed by a medical provider? If yes, list them: _____ Do you take herbs, vitamins, or over-the-counter meds? If yes, list them: _____				
Do you use other drugs (example: marijuana, cocaine, or IV drugs)? What do you use? _____				
Do you use alcohol? How much _____				
Do you smoke? If yes, how many cigarettes per day: ____				

FAMILY HISTORY

(HAVE YOUR GRANDPARENTS, PARENTS, BROTHERS, OR SISTERS EVER HAD):	YES	NO	?	STAFF NOTES ONLY
Heart Problems or stroke (before age 50)				
High Blood Pressure				
Alcoholism/drug abuse				
Birth Defects/Retardation What type? _____				
Blood clots in arms/legs/chest				
Blood disease or bleeding problems				
Bone problems (brittle, weak bones)				
Breast/ovarian/uterine/prostate/penile cancer				
Breast lumps or cysts				
Colon cancer				
Did your mother take DES (a hormone to prevent miscarriage)				
Diabetes (high sugar)				
Epilepsy/Seizures				

SEXUAL HISTORY

Have you ever had sexual intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of first sexual activity? _____
Were your partners: <input type="checkbox"/> Women <input type="checkbox"/> Men <input type="checkbox"/> Both	When did you have sex last? _____
What kind of sex have you had in the past 60 days? <input type="checkbox"/> Penis <input type="checkbox"/> Mouth <input type="checkbox"/> Rectum <input type="checkbox"/> No Sex	Date of your last prostate exam: _____
How many partners have you had in the past 60 days? _____ Past 12 months? _____	
Do you feel safe from violence in your personal relationships? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have symptoms of a genital infection? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:(check the ones you have) <input type="checkbox"/> Penile Discharge <input type="checkbox"/> Rash <input type="checkbox"/> Bumps <input type="checkbox"/> Sores <input type="checkbox"/> Pain during sex <input type="checkbox"/> Pain or bleeding with ejaculation <input type="checkbox"/> Burning <input type="checkbox"/> Stool or anal problems <input type="checkbox"/> Difficulty urinating or dribbling <input type="checkbox"/> Urgent or frequent urination	

CONTRACEPTIVE HISTORY

	YES	NO
Have you ever fathered a child?		
Have you or your partner ever used a method of birth control?		
What method did you use last?		
Are you still using that method? If no, when did you stop? _____		
Where was the method obtained or prescribed?		
Any problems with it?	How long have you used it?	

LABEL

PARTNER HISTORY		
Please check if your partner(s) has a history of any of these activities	YES	NO
Illegal drug use?		
Multiple partners?		
Bisexuality?		
History of Sexually Transmitted Infections?		
History of HIV?		
Homosexuality		

ALL INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT WRITTEN CONSENT, UNLESS REQUIRED BY LAW.

To the best of my knowledge, the above information is complete and accurate and has been reviewed by the staff.

Client Signature

Date

Reviewed By

Date