



# Male Health History

Form I

Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

### Medical History

Have you or anyone in your immediate family had a history of the following:

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Congenital anomalies/genetic disorders                | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Multiple births                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Diabetes mellitus                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Cancers   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Heart disease/hypertension, dizziness, swelling       | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Blood disorders (blood clots, etc)                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Mental illness  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Autoimmune (RA, MS, Lupus, etc.)                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other medical issues (epilepsy, thyroid, liver, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |

Have you had a history of the following:

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Frequent UTIs   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Infectious diseases (hepatitis, jaundice, mono)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Blood transfusions  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Operations/accidents  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Other medical issues (migraines, frequent cough, SOB, TB, heartburn, bowel, other: _____)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Date of last STD/HIV screening: ____/____/____ <input type="checkbox"/> Never screened<br>Diagnosed STDs and treatment dates: _____               |                          |                          |
| 7. Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No How many cigarettes per day? _____   |                          |                          |
| 8. Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>How many alcoholic drinks per day? _____ On the weekends? _____ |                          |                          |
| 9. What types of street drugs have you used and how often?   |                          |                          |
| <u>Drug</u> <u>Last Used</u> <u>How Often</u> <u>Length of Use</u>   |                          |                          |

Have you received:

- Gardasil Vaccine     Yes     No  
Hepatitis B Vaccine     Yes     No

Please list any medications you are taking:  
(include any herbal supplements and vitamins)

\_\_\_\_\_  
\_\_\_\_\_

Medication Allergies \_\_\_\_\_

Latex Allergy?     Yes     No

**Staff Comments:**

Are you currently experiencing any of the following?

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| Persistent sore throat   | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital discharge/odor/itching   | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain with intercourse  | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in pelvis/lower abdomen/lower back  | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning with urination   | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever/chilling   | <input type="checkbox"/> | <input type="checkbox"/> |
| Lesions: genital <input type="checkbox"/> non-genital <input type="checkbox"/> |                          |                          |
| How long have you had these symptoms? _____                                    |                          |                          |

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_