

MALE HEALTH HISTORY

Name: _____ Date of Birth: _____
Last First

The reason for my visit is: STD testing bumps or sores/genital area pain or burning with urination
 other: _____

<p>Name of your primary health care practitioner/clinic: _____ <input type="checkbox"/> I have none</p> <p>Medical care in the past year: <input type="checkbox"/> None <input type="checkbox"/> work-related injury: _____ other: _____</p> <p>List all prescription or "over-the-counter" drugs you have taken in the past 90 days: (Including: herbal & vitamins) <input type="checkbox"/> aspirin <input type="checkbox"/> Tylenol <input type="checkbox"/> Ibuprofen/Advil <input type="checkbox"/> multivitamin <input type="checkbox"/> hemorrhoid cream <input type="checkbox"/> Other: _____</p>	<p>Are you allergic to or ever had a reaction to: <input type="checkbox"/> iodine <input type="checkbox"/> sulfa <input type="checkbox"/> local anesthetics <input type="checkbox"/> penicillin <input type="checkbox"/> aspirin <input type="checkbox"/> tetracycline <input type="checkbox"/> metals <input type="checkbox"/> other: _____ <input type="checkbox"/> NONE KNOWN</p> <p>Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current Packs/Day: _____ Chews/Day: _____ Previous Attempts at Stopping? <input type="checkbox"/> Yes <input type="checkbox"/> No Method tried: <input type="checkbox"/> cold turkey <input type="checkbox"/> nicotine patch <input type="checkbox"/> Zyban <input type="checkbox"/> hypnosis <input type="checkbox"/> acupuncture <input type="checkbox"/> other: _____ Interested in trying to stop again? <input type="checkbox"/> yes <input type="checkbox"/> no</p>
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	Do you now have, or have you ever had:	YES	NO	STAFF COMMENTS
GENERAL HEALTH	1. Serious illness/hospitalizations			
	2. Outpatient surgeries			
	3. Cancer			
	4. Diabetes			
	5. Thyroid disease			
	6. Frequent or severe headaches			
	7. Neurologic disorders (seizures, numbness)			
	8. Blurred, double, or loss of vision			
	9. Severe chest pain/difficulty breathing			
	10. Heart problems/murmurs/rheumatic fever			
	11. High blood fat levels (i.e. cholesterol)			
	12. High blood pressure or stroke			
	13. Severe pain/swelling in legs			
	14. Blood clots in veins/varicose veins			
	15. Lower abdominal pain or pressure			
	16. Stomach/intestinal problems			
	17. Obesity/anorexia/bulimia			
	18. Mono/hepatitis			
	19. Gall bladder or liver disease			
	20. Kidney/bladder problems/infections			
GENITAL HEALTH	21. Pain/burning or frequent urination			
	22. Discharge from penis			
	23. Bumps /sores on penis, scrotum or rectum			
	24. Gonorrhea, syphilis, chlamydia, herpes or warts			
	25. Cold sores or fever blisters			
	26. Hernia			
	27. Hemorrhoid(s)			

NAME _____

CHART # _____

MENTAL HEALTH

- 28. How often do you drink alcohol? never
 daily weekly weekends special occasions
- 29. Select all that apply to you:
 use alcohol to get to sleep
 am in alcohol recovery
 use alcohol to feel comfortable with others
 annoyed by people criticizing your
 felt that you ought to cut down drinking
 ever had a drink first thing in the day?
- 30. How many drinks does it take to make you feel high? 1-2 3-4 4-6 more than 6
- 31. Select all that apply to you:
 past depression current depression
 thought about ending my life
 medical care or hospitalization for drug, alcohol or mental health problems
 medication(s) for any of the above problems:

- 32. Check any of the following that you've used in the past 6 months: *Huffing* inhalants
 Ecstasy Marijuana Cocaine or Crack
 Amphetamines IV drugs other: _____
- 33. Have you ever been subjected to physical or emotional abuse? yes no
- 34. Have you ever abused anyone? yes no
- 35. Is there anyone in your life that makes you feel afraid or that you have to "walk on eggshells?" yes no
- 36. How would you describe your current romantic relationship? Good Fair Poor None
- 37. How do you and your partner resolve conflict?
 argue silence avoid talking about issue
 compromise I give in getting physical
- 38. Does your partner need to know where you are/who you're with much of the time? yes no

STAFF COMMENTS: _____

SEXUAL HEALTH

- 39. Do you *examine* your own testicles monthly? Yes No
- 40. Have you been sexually active? Yes your age at first intercourse: _____ No
- 41. Do you or have you had sex with men women both
- 42. How often do you use condoms? always sometimes never
- 43. Do you practice: vaginal sex oral sex anal/rectal sex
- 44. Has/have your partner(s) been: treated for a sexually transmitted disease?
 complaining of genital pain or discomfort, drainage or sores? not currently never
- 45. Have you had more than one sex partner in the last 3 months? Yes No
- 46. Has your partner(s) had more than one sex partner in the past 3 months? Yes No
- 47. Have you ever had sex against your will? Yes No
- 48. Have you ever been involved with an unplanned pregnancy? Yes No
- 49. What is your present method of birth control? none abstinence
 condom withdrawal
- 50. Have you ever had a condom break while using? Yes No

FAMILY

- 51. Do your **birth** parents or siblings have:
 - a. Diabetes Yes No Unknown
 - b. Death from heart attack before 50 Yes No Unknown
 - c. High blood fat levels (i.e., cholesterol) Yes No Unknown
 - d. High blood pressure Yes No Unknown
 - e. Stroke Yes No Unknown
 - f. Testicular/Prostate cancer Yes No Unknown

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of client: _____

STAFF COMMENTS: _____

REVIEWED BY: _____ Date: _____