women's & men's health services of the Coastal Bend, Inc.

MALE COMPREHENSIVE HEALTH HISTORY

Date ____/____/____ NAME_____ DOB ____/____/____ AGE____

Yes No

___ ___ Are you allergic to any medications, latex, foods, products, or anesthesia?List:_____

___ ___ Are you currently taking medications (include herbal remedies, vitamins, over-the-counter medication) List:_____

___ ___ Are you currently under a health care provider's care? If so, why? _____ With whom? _____

FAMILY HISTORY

Are you adopted? Yes___ No____

Have your biological family (parents, brothers, sisters) had any of the following?

Yes	No		Who?
___	___	High cholesterol	_____
___	___	Diabetes	_____
___	___	High blood pressure	_____
___	___	Cancer	_____
___	___	Heart Attack before age 55	_____
___	___	Stroke before age	_____
___	___	Sickle cell anemia/trait	_____
		Other	

MEDICAL HISTORY (Please check all that apply now or in the past.)

Yes No

___ ___ Blood transfusions
___ ___ Heart disease/Murmurs/Valves
___ ___ Chest pain or shortness of breath
___ ___ High blood pressure
___ ___ Stroke
___ ___ Blood clots or clotting disorder (such as hemophilia)
___ ___ Varicose veins or inflammation of veins
___ ___ Numbness of arms or legs
___ ___ Scarlet fever
___ ___ Rheumatic fever
___ ___ High cholesterol / triglycerides/ blood fats
___ ___ Anemia/Low iron
___ ___ Sickle Cell disease
___ ___ Suicidal depression
___ ___ Anxiety or other psychological problems
___ ___ Psychiatric treatment
___ ___ Lupus
___ ___ Migraine headaches
___ ___ Frequent headaches
___ ___ Cancer
___ ___ Blurred vision or loss of vision
___ ___ Seizures or epilepsy
___ ___ Liver disease, hepatitis, jaundice, mononucleosis
___ ___ Gall bladder problems
___ ___ Birth defects, genetic problems
___ ___ Bladder or kidney problems
___ ___ Penis discharge
___ ___ Breast lump

Yes No

___ ___ Kidney disease
___ ___ Frequent urinary bladder infections
___ ___ Stomach or bowel problems
___ ___ Thyroid problems
___ ___ Diabetes
___ ___ Asthma, chronic cough or breathing problems
___ ___ Sleep apnea
___ ___ Night sweats
___ ___ Skin allergies or irritation
___ ___ Breast lump, tumor, discharge or surgery
___ ___ Testicular problems/surgery
___ ___ Chronic fatigue > 6 months
___ ___ TB or other lung disease
___ ___ Eye problems (except glasses or contacts)
___ ___ Hearing problems
___ ___ Frequent nosebleeds or sore throats
___ ___ Arthritis, osteoporosis
___ ___ Acne or other skin problems
___ ___ Exposure to occupational hazards or environmental toxins
___ ___ Chlamydia _____
___ ___ Gonorrhea _____
___ ___ Syphilis _____
___ ___ Herpes _____
___ ___ Warts/HPV _____
___ ___ HIV _____
___ ___ Pain with sex? Other sex problems?

Are you up to date on immunizations (shots) DPT, rubella, Hepatitis, polio, meningitis, measles? Yes____ No____
HPV? Yes____ No____

List any surgeries, severe illnesses, injuries or other medical conditions you have had or have now and approximate date:

_____

Are you planning any major surgery requiring long term bed rest? Yes___ No____

Do you have any of the following symptoms?

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Discharge	___	___	Rash	___	___	Swollen glands	___	___	Itch
___	___	Pain when urinating	___	___	Genital warts	___	___	Fever/chills	___	___	Testicular Pain
___	___	Sores	___	___	Abdominal pain	___	___	Unexplained weight loss or gain			

List any self-treatment for any of the above symptoms? _____

STI/HIV RISK ASSESSMENT

Date of last sexual encounter?_____

Number of sex partners in past year? _____ Number of partners in your life? Women_____ Men____

Were any of your partners a hemophiliac? Yes___ No___ Infected with HIV/AIDS? Yes___ No___ A street drug user? Yes___ No___

Have you ever shared needles? (drugs, tattooing, piercing)? Yes____ No___

Any partners test positive for STI? Yes___ No___ If yes, what?_____

Reproductive Life Plan	**Yes**	**No**	
Do you have children?	___	___	
Do you want any/more children at this time?	___	___	
Would you like more information on any method of birth control	___	___	what_____

Birth control history	**Yes**	**No**	
Do you use condoms regularly?	___	___	
Do you support your partner(s)' use of birth control	___	___	How_____

Health Habits (All health information is confidential and cannot be released without your permission except physical or sexual abuse of a minor which we must report to authorities)

Yes	No	
___	___	Do you exercise regularly?
___	___	Do you consider your diet and eating habits healthy?
___	___	Do you smoke cigarettes? If so, number of cigarettes a day?_____ How long have you smoked?_____
___	___	Do you use other forms of tobacco?
___	___	Do you do self-testicular exam? How often? ___Monthly ___Seldom
___	___	Do you drink alcohol excessively?
___	___	Do you use drugs (marijuana, cocaine, etc)?
___	___	Have you ever used IV drugs?
___	___	Has a current or past partner ever used IV drugs, or had a partner who used IV drugs?
___	___	Are others concerned with your alcohol and/or drug habits?
___	___	Have you been physically or sexually abused?
___	___	Are you afraid of your partner(s) or a family member?
___	___	Is someone forcing or coercing you to have sex?

Education: please indicate highest level completed_____

Who helps and supports you with your problems?_____

What questions can we answer for you today?_____

Patient Signature_____Date_____

Reviewed By_____ Date_____

Updated By _____ Date_____

Updated By_____ Date_____