INITIAL MEDICAL HISTORY: MALE

Name _____ Date of Birth _____ Age _____ Chart # _____

Reason for visit to Family Planning _____

Primary Care Doctor _____ Date of last physical _____ Date of last genital exam _____

Current Medications _____

Medication allergies & reactions _____

Current over-the-counter medicines, dietary supplements, herbal preparations, etc. _____

_____

HEALTH HISTORY: CHECK ALL THAT APPLY FOR YOURSELF AND YOUR FAMILY MEMBERS (parents, brothers & sisters, grand parents, aunts & uncles) – biological family members only. Were you adopted? [ ] No [ ] Yes
(If yes and if you know your biological family's health history, please include that information in this section.)

FAMILY / PAST MEDICAL HISTORY

	Circle Y for yes or N for no.	Self	Family
1.	Cancer of the prostate	Y N	Y N
2.	Emotional problem(s): anxiety, panic, depression, bipolar, etc.	Y N	Y N
3.	Alcohol use problems	Y N	Y N
4.	Drug use problems	Y N	Y N
5.	Mother took DES while pregnant	Y N	Y N
6.	Inherited / genetic disorders	Y N	Y N
7.	Liver disease, hepatitis, or mononucleosis	Y N	
8.	Prostatitis	Y N	
9.	Testicular tumors	Y N	
10.	Urinary tract infections or kidney disease	Y N	
11.	Other serious illness	Y N	
12.	Hospitalization	Y N	
13.	Surgery	Y N	

SOCIAL HISTORY

Please answer the following questions about yourself.

	Circle Y for yes or N for no.	
1.	How often do you do a testicular self-exam?	
2.	Do you want info about prostate cancer screening	Y N
3.	Do you use tobacco (smoke, chew, snuff, etc.)?	Y N
	a. If yes, how much (many) per day?	
	b. If yes, at what age did you start?	
4.	Do you drink alcohol?	Y N
	a. If yes, what do you usually drink?	
	b. If yes, how often do you drink?	
	c. If yes, how many drinks each time?	
5.	Do you or have you used "street drugs"?	Y N
	a. If yes, what drugs?	
	b. If yes, how often do you use?	
	c. Have you or any of your sexual partners ever injected drugs?	Y N
6.	If you use them, are you concerned about your use of tobacco, alcohol, and/or "street drugs"?	Y N
7.	Do you use or have you ever used "performance enhancing" steroids?	Y N

FOR CLINIC STAFF USE ONLY

Client's/Patient's Initials _____ Counselor's / Reviewer's Initials _____ Date _____