

MALE MEDICAL HISTORY

NAME _____ AGE _____ DOB _____

Marital Status S M D W Separated Living with someone

Allergies _____

Hospitalizations/Surgery _____

Current Meds _____

Major Illnesses/Injuries _____

Reason for today's visit: _____

Family MD: _____ Date of Last Visit: _____ Abnormal Findings: Y N

Do you use: Tobacco products? Y N, If yes type/amount per day _____ Alcohol/drugs? Y N, if yes type/amount _____

Have You had: German Measles(Rubella)? Yes No Vaccinated Unknown Normal Childhood Vaccinations? Y N

Did your mother take DES(a medication to prevent miscarriages) when she was pregnant with you? Yes No

Family History: Has any member of your family(parents,siblings,grandparents) had any of the following? Please Mark all that apply and state relationship: _____
 Check here if you do not know your biological family history

Diabetes _____ Stroke _____ Heart Disease _____ Blood Clots _____

High Blood Pressure _____ High Cholesterol _____ Sickle Cell Anemia _____

Cancer(if yes, type and relationship) _____

Birth Defects/Genetic Diseases(if yes, type and relationship) _____ Other _____

Past Medical History: Do you have, or have you ever had(Check all that apply):

GENERAL Frequent or Severe Headaches

Unexplained Weight loss

Dizziness/Fainting

Seizures/Epilepsy/Convulsions

Skin Disorders

Leg pain/tenderness, swelling

Joint Pain

Recent Chills/Fever

Weight Problems

HEENT Vision Problems(blurring/double vision, spots)

Hearing Problems

Difficulty Swallowing

Runny Nose

LUNGS Chronic Cough

Hay Fever

Asthma

TB

BLOOD Transfusions/Blood Products

Anemia

High Cholesterol

Blood Clots

Unusual Bruising

Blood Disorders

Injectable Drug Use

PSYCHOSOCIAL Depression/Anxiety

History of Abuse

Suicidal Thoughts

ENDOCRINE

Diabetes

Thyroid Disorder

Increased Thirst

HEART

Chest pain

Difficulty Breathing

Rheumatic Fever

Mitral Valve Prolapse

Heart Murmur

High Blood Pressure

Stroke

ABDOMEN

Gallbladder Disease

Gastric Ulcers

Heartburn

Pain

LIVER

Hepatitis

Jaundice

Mononucleosis

CANCER

TYPE _____

BREASTS

Lump

Nipple Discharge

BOWELS

Constipation/Diarrhea

Blood in Stool

Rectal Pain/Bleeding

UROLOGICAL/GENITAL HISTORY

- Kidney/Bladder Problems or Infections
- Blood in Urine
- Nighttime Urination
- Pain, burning, difficulty or frequent urination
- Injury to testicles or groin
- Hemia/Hydrocele/Varicocele
- Discharge from Penis
- Sores/Bumps/Rash in genital area
- Pain/bleeding with ejaculation or intercourse
- Sexually Transmitted Infection (Gonorrhea, Chlamydia, Warts, Herpes, Hepatitis)
Type: _____
- Do you have HIV? Yes No Unknown

Have you urinated in the last hour Yes No

Other Concerns/Pertinent History: _____

SEXUAL HISTORY

- Are you currently Sexually Active Yes No
- Lifetime Sexual Partners: _____
- Age of First Intercourse: _____
- Are your current and past partners: Male Female Both
- How many current sexual partners do you have? _____
- Does your current sexual partner have STI symptoms? Yes No
- Has your current or past sexual partner(s) had an STI or HIV?
Yes No Unknown, If yes type _____
- Do your current or past sexual partner(s) inject drugs? Yes No
- Have you had more than one sexual partner in the last 6 months? Yes No
- What types of Sex do you have: Vaginal Oral Anal
- Have you ever been forced into an activity you did not want to do? Yes No

FAMILY PLANS

- Have you fathered any children? Yes No, if yes how many _____
- Do you plan future children? Yes No Undecided
- Are you and your partner(s) currently using birth control?
 Yes No Unsure, if yes, which type(s) _____
- Do you want more information about birth control? Yes No

NUTRITION

How many servings of the following do eat per day: Fruits _____ Vegetables _____ Nuts/Beans _____
Eggs/Meats _____ Milk/Dairy _____ Caffeine _____

EDUCATION:

- | | | |
|--|--|---|
| Physical Exam <input type="checkbox"/> | Condom Fact Sheet <input type="checkbox"/> | Contraception <input type="checkbox"/> |
| Lab tests/Results <input type="checkbox"/> | Smoking Cessation <input type="checkbox"/> | Nutrition <input type="checkbox"/> |
| STI's/HIV <input type="checkbox"/> | Emergency Information <input type="checkbox"/> | Self Testicular Exam <input type="checkbox"/> |
| Referral: _____ NA <input type="checkbox"/> | Next Visit _____ NA <input type="checkbox"/> | Adolescent Ed. <input type="checkbox"/> NA <input type="checkbox"/> |
| Info on Prescriptions Rec'd <input type="checkbox"/> NA <input type="checkbox"/> | | (to include Abstinence, Family involvement, & sexual coercion) |

ASSURANCE OF CONFIDENTIALITY

This medical record is confidential and will not be released to anyone without your written consent, except as may be required by law.

To the best of my knowledge, the above history is accurate and complete. Educational information has been given to me as indicated above. I have been given the opportunity to ask questions. If I am 18 years old or younger, I have been strongly encouraged to discuss my family planning needs with my parents. If I use tobacco, I have been given information and understand the health risk of using tobacco. I have been told that if tests are taken for sexually transmitted infections (STIs), reporting of positive results to public health agencies is required by law. I understand that the Nebraska Health and Human Services may access my medical record to determine the quality of services provided by this agency.

CONSENT TO TREATMENT: I hereby consent to examination, consultation, and treatment at this clinic.

Patient Signature: _____ Staff Signature: _____ Date: _____