

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

Name: \_\_\_\_\_

### **Male History Form**

To protect your health, please provide us with the following information, if applicable to you.

<b>Are you allergic to any medications or substances?</b> If yes, please list: _____	<input type="radio"/> Yes <input type="radio"/> No
<b>Are you being treated for anything at this time?</b> If yes, please list: _____	<input type="radio"/> Yes <input type="radio"/> No
<b>Who is your primary healthcare provider?</b> _____	

<b>Your Past and Current Medical History (Check all that apply)</b>	
<input type="radio"/> Blood clots in your lungs or veins	<input type="radio"/> Seizures
<input type="radio"/> Blood coagulation disorder	<input type="radio"/> Depression, anxiety or mood disorder treated by a doctor
<input type="radio"/> Heart Problems/disease	<input type="radio"/> Vision/hearing difficulty
<input type="radio"/> High Blood Pressure	<input type="radio"/> Learning disability
<input type="radio"/> High cholesterol	<input type="radio"/> Lung disease (ex: asthma, COPD)
<input type="radio"/> Stroke	<input type="radio"/> Ulcers
<input type="radio"/> Transient ischemic attack (TIA)	<input type="radio"/> Liver disease/Hepatitis
<input type="radio"/> Hyperthyroid	<input type="radio"/> Gallbladder disease
<input type="radio"/> Hypothyroid	<input type="radio"/> Kidney disease
<input type="radio"/> Migraine Headaches (headaches with vision problems or vomiting)	<input type="radio"/> Inflammatory bowel disease (ulcerative colitis, Crohn's)
<input type="radio"/> Diabetes	<input type="radio"/> Cancer
<input type="radio"/> Lupus	
<input type="radio"/> Other: _____	
<input type="radio"/> None of the above	

<b>Surgical History (Check all that apply)</b>
<input type="radio"/> Vasectomy
<input type="radio"/> Organ Transplant
<input type="radio"/> Bariatric (weight loss) surgery such as gastric bypass
<input type="radio"/> Other: _____
<input type="radio"/> None of the above

<b>Health History</b>			
What are your plans for having children: _____			
Have you had a same-sex partner (homosexual)?	<input type="radio"/> Yes <input type="radio"/> No		
Has your partner had a same-sex partner?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know		
Do you have a regular partner now?	<input type="radio"/> Yes <input type="radio"/> No		
Have you ever had any of the following sexually transmitted infections? Check all that apply.			
<input type="radio"/> Chlamydia	<input type="radio"/> Gonorrhea	<input type="radio"/> Syphilis	<input type="radio"/> Trichomonas
<input type="radio"/> Herpes	<input type="radio"/> Warts	<input type="radio"/> HPV	

Client Label Here

**Social History** (Check all that apply)

Smoke tobacco       Chew tobacco       Use to smoke/chew tobacco. Quit date: \_\_\_\_\_  
 How many cigarettes do you smoke a day? \_\_\_\_\_  
 Vape

Drink alcohol  
How many drinks do you have per day? \_\_\_\_\_

Street drugs  
If you use street drugs, **how recently** and **what did you use?** \_\_\_\_\_  
\_\_\_\_\_

Have you used IV drugs (needles)?  Yes    No

Has your partner used IV drugs (needles)?  Yes    No

**Family History** (Check all that apply)

Have any of your immediate family members (Mother, Father, Brother, Sister, Grandparents, Aunt/Uncle, etc.) ever had:

Heart attack before age 50       High cholesterol       Menopause before age 45  
 High blood pressure       Diabetes       Mental Illness  
 Stroke       Breast or reproductive organ cancer       Compression fractures  
 Other: \_\_\_\_\_