

Date: _____

Name: _____

Supplemental Male History Form

Reason for today's visit:

Please check any **symptoms** you are having today and indicate **how long** you have had them:

- | | |
|--|--|
| <input type="checkbox"/> Partner diagnosed with an STD | |
| <input type="checkbox"/> Burning with urination | |
| <input type="checkbox"/> Genital itching | |
| <input type="checkbox"/> Drips or discharge from penis | |
| <input type="checkbox"/> Blisters or sores | |
| <input type="checkbox"/> Rash | |
| <input type="checkbox"/> Bumps, warts | |
| <input type="checkbox"/> Other: | |

General Family Planning / Health Information:

- | | |
|---|--|
| Would you like to have (more) children in the next year? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| What is your and/or your partner's current birth control method? | |
| Date of last child's delivery: | |
| Have you had a new partner since your last visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has your partner had a new partner since your last visit? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know |
| Do you use condoms for STI/STD protection? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes |
| When did you last have unprotected (no condom) sex? | |
| What are your sexual practices (current and past)?
Check all that applies: | <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Anal |
| Are your sex partners: (check all that applies) | <input type="checkbox"/> Males <input type="checkbox"/> Females
<input type="checkbox"/> Other: |
| When was your last HIV test? | |

Do you have any health problems? Yes No
If yes, please list: _____

List medications/supplements you are **currently taking**: None

List any medication/substance **allergies** you have: None

- | | |
|---|---|
| Has anyone ever emotionally, physically, sexually, or verbally abused you? | <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, have you had counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you being pressured to have sex when it is not your choice? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does anyone try to prevent you from leaving your job or residence? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have control over your own identification documents? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you have a partner, do you feel safe with this person? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not have a partner |
| If you are under 18 years of age, do you have a trusted adult to turn to for support? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Current living situation: Home Homeless Sober Living Environment Other:

What confidential telephone number can we use to call you? _____

Client Label Here