Planned Parenthood of Delaware

Male Medical History

MEDICAL / FAMILY / IMMUNIZATION HISTORY

Allergies

Yes	No	
❑	❑	Are you allergic to any drugs, medicines, or latex?
		If yes, what and what is the reaction?

Current Medications

Yes	No	
❑	❑	Do you take any medication (prescription, over the counter, vitamins, herbs, etc.)?
		If yes, list medication and doses:

Past Medical History

Have you ever had: (please ✓ Yes or No):

Yes	No		Yes	No	
❑	❑	Anemia	❑	❑	High Cholesterol
❑	❑	Asthma	❑	❑	High blood pressure
❑	❑	Benign Prostatic Hypertrophy	❑	❑	Infertility
❑	❑	Bleeding disorder	❑	❑	Crohn's/colitis/ constipation
❑	❑	Blood transfusion	❑	❑	Kidney failure
❑	❑	Cancer	❑	❑	Liver disease
❑	❑	Stroke	❑	❑	Migraine
❑	❑	Chlamydia	❑	❑	Heart attack
❑	❑	Blood clot in leg	❑	❑	Osteoporosis
❑	❑	Depression	❑	❑	Psychiatric disorder
❑	❑	Diabetes	❑	❑	Blood clot in the lungs
❑	❑	Drug/alcohol abuse	❑	❑	Seizure/epilepsy
❑	❑	Eating disorder	❑	❑	Suicide attempt
❑	❑	Gallbladder disease	❑	❑	Syphilis
❑	❑	Genital herpes	❑	❑	Thyroid disease
❑	❑	Genital warts	❑	❑	Tuberculosis
❑	❑	Gonorrhea	❑	❑	UTI, recurrent
❑	❑	Heart failure	❑	❑	Valvular heart disease
❑	❑	Hepatitis B	❑	❑	Kidney stones
❑	❑	Hepatitis C	❑	❑	Trichomonias
❑	❑	HIV/AIDS	❑	❑	Other_____
❑	❑	Clotting disorder			_____

Past Surgical History

Do you or have you ever had?		Year
Yes	No	
❑	❑	Appendectomy _____
❑	❑	Cataract extraction _____
❑	❑	Gallbladder removed _____
❑	❑	Gastric bypass _____
❑	❑	Heart surgery _____
❑	❑	Hernia repair _____
❑	❑	Liver biopsy _____
❑	❑	Prostate biopsy _____
❑	❑	TURP _____
❑	❑	Vasectomy _____
❑	❑	OTHER _____
❑	❑	OTHER_____ _____
❑	❑	OTHER_____ _____

Family History

Yes No
❑ ❑ Are you adopted?

Has anyone in your family ever had the following?

Yes	No		Who?	Age when Diagnosed
❑	❑	Blood disease	_____	_____
❑	❑	Coronary artery disease	_____	_____
❑	❑	Heart attack	_____	_____
❑	❑	Blood Clots	_____	_____
❑	❑	CVA (Stroke)	_____	_____
❑	❑	Diabetes	_____	_____
❑	❑	High Cholesterol	_____	_____
❑	❑	High blood pressure	_____	_____
❑	❑	Osteoporosis	_____	_____
❑	❑	Kidney failure	_____	_____
❑	❑	Breast cancer	_____	_____
❑	❑	Testicular cancer	_____	_____
❑	❑	Colon cancer	_____	_____
❑	❑	Other_____	_____	_____

Immunization History

Yes No
❑ ❑ Are your immunizations up to date?
❑ ❑ Have you received your MMR vaccination?
If yes, when? _____
❑ ❑ Have you received HPV?
If yes, how many doses? ❑ 1 ❑ 2 ❑ 3

REPRODUCTIVE HISTORY

Contraceptive History

Which birth control methods have you used in the past?

❑ Male condom	❑Unplanned pregnancy
❑ Partner method	❑None, same sex partner
❑ Male sterilization	❑None, other reason
❑ Withdrawal	❑Unknown
❑ Not sexually active	❑Other_____

Comments/problems with method, list below:

SOCIAL HISTORY

Sexual Practices / STI Risk

Yes No
❑ ❑ Have you had intercourse yet?

_____ If yes, how old were you the first time you had intercourse?
_____ How many sex partners have you had in the past year?

Check the types of sexual activity you have had?
❑ Anal insertive ❑ Anal receptive ❑Anal both
❑ Vaginal ❑ Oral ❑ None

Your partners are: ❑ Men ❑ Women ❑ Both

Your partner's partners:
❑ Men ❑ Women ❑ Both ❑ Unknown

Condom use: ❑ Always ❑Sometimes ❑Never

What method of birth control are you currently using?

Clinician Initials_____

Planned Parenthood of Delaware

Male Medical History

Sexual Practices / STI Risk (cont'd)			
Yes	**No**	**Unknown**	
❑	❑	❑	Is your partner having sex only with you?
❑	❑		Have you had a new partner since your last STI test?
❑	❑		Have you had more than one partner in the last 12 months?
❑	❑	❑	Are you exposed to STI?
❑	❑	❑	Has a partner had STI symptoms in the past 60 days?
❑	❑		Do you share needles?
❑	❑		Have you ever accepted money/drugs for sex?
❑	❑	❑	Does your partner use IV drugs?
❑	❑	❑	Have you or a partner been incarcerated?
❑	❑		Have you had anonymous partner(s)?
❑	❑	❑	Does your partner have other risk behaviors?
❑	❑		Did you have a blood transfusion before 1985?

Substance Abuse	
Yes	**No**
❑	❑ Have you used street drugs in the past? Type_____
❑	❑Are you currently using street drugs? Type_____
❑	❑Do you use alcohol? Drinks_____per day/week/month
❑	❑Do you have problems with drugs or alcohol?

Do you use tobacco?

❑Yes ❑No ❑Formerly Type_____

How much/often? _____

Lifestyle Challenges / Support	
Yes	**No**
❑	❑ Have you/are you experiencing abuse?
❑	❑ Have you been forced to have sex?

Patient Signature_____ Date_____