MALE HISTORY

Planned Parenthood Southeast, Inc.
404.688.9300

[Patient Label]

DATE: _____ AGE_____

A. REVIEW OF SYSTEMS:		
YES	**NO**	**GENERAL**
		1. My health is generally good
		2. Smoke cigarettes. If yes how many per day? _____ How long? _____
		3. Alcohol use. If yes, how many drinks / week?____
		4. Cancer If yes, where / when?
		5. Are you being treated for any illness / condition now? If yes, what?
		6. Do you currently take: medicine prescriptions, over the counter or herbal? If yes, name: _____
		7. Do you have other Health Care Providers? If yes, list:
		CARDIOVASCULAR
		8. Mitral Vale Prolapse
		9. Heart Murmur
		10.Varicose Veins
		11. Blood Clots (head / leg / lungs)
		12. Stroke or Stroke-like problems
		13. High Blood Pressure / Hypertension
		14. High Cholesterol (>200)
		RESPIRATORY
		15. Chronic Cough or other Breathing Problems / Asthma
		16. Tuberculosis (TB) or Exposure to Tuberculosis
		GASTROINTESTINAL
		17. Stomach or Bowel Problems: Ulcer / IBS / Constipation
		18. Liver Problems: Hepatitis / Tumor / Jaundice
		19. Gallbladder Problems
		GENITOURINARY
		20. Bladder or Kidney Problems
		21. Testicle inflammation, lumps or injury
		22. Discharge
		23. Blood in urine
		24. Monthly testicular self-exams
		SKIN
		25. Acne or Other Skin Problems. What?
		NEUROLOGICAL
		26. Seizures
		PSYCHOLOGICAL
		27. Depression, Requiring Treatment
		ENDOCRINE
		28. Thyroid Problems
		29. Diabetes
		HEMATOLOGICAL / LYMPHATIC
		30. Anemia
		31. Blood Clotting Disorder
		ALLERGY / IMMUNOLOGY
		32. Are you Allergic to any Drug, Medication, Latex or other Substance? If yes, what?
		33. Have you had? Vaccine for Hepatitis B

B. HOSPITALIZATION AND SURGERIES

Year	Reason

C. FAMILY HISTORY

Are you Adopted? □ Yes □ No

Have your **Biological Family** (parents, brothers, sisters) had any of the following?

YES	NO	DIAGNOSIS	RELATIVE
		Diabetes	
		Heart Attack / Stroke before age 55 Male / before age 65 Female	
		High Blood Pressure / Hypertension	
		High Cholesterol or fats	
		Cancer	
		Did your Mother take DES when pregnant with you to prevent a miscarriage?	

C. SEXUAL HISTORY / STD RISK

34. Sexual Preference? □ Male □ Female □ Both
35. Number of sexual partners during past year? _____
36. Are you currently having sex? □ Yes □ No ( ) vaginal ( ) anal ( )
37. Length of time with current partner? _____
38. Do you or your partner have other partners? □ Yes □ No □ N/A
39. Do you use Condoms: □ Always □ Sometimes □ Never
40. Have you ever had a Sexually Transmitted Infection? □ Yes □ No
( ) Chlamydia ( ) Gonorrhea ( ) Genital Warts ( ) Herpes
( ) Syphilis ( ) Trichomonas ( ) Other
41. Present method of birth control? ( ) Abstinence ( ) Withdrawal
( ) Condoms ( ) Vasectomy ( ) Partner's method _____

YES	NO	HIV RISKS:
		42) Are you HIV positive? If yes, when? 43) Have you ever used street drugs? If yes, what drugs and when?
		44) Have you received blood or blood products since 1978?
		45) Was any partner: □ A street drug user □ A hemophiliac □ Infected with HIV / AIDS?
		46) Have you shared needles? Example: Injecting drugs, tattooing, or piercing

_____ _____

Client Signature **Date**

Staff Comments:

_____

_____

_____

Signature _____ Date _____