MALE MEDICAL HISTORY INFORMATION

Name_____

Any concerns/issues you would like to discuss today? _____

_____

Vitals: BP :_____/_____,Pulse:_____, WT:_____,HT:_____,Temp:_____

Today's date_____ **Age**_____

MALE MEDICAL HISTORY

Birth control method ☐N/A	
Number of sexual partners in the last year	
Are you currently sexually active?	Y / N
With whom do you have sex? Males only Females only Both Males and Females	
Have you had any sexually transmitted diseases? If yes, which ones?	Y / N

Any history of sexual abuse or domestic violence?	Y / N
Do you feel safe in your current relationship?	Y / N
Would you like to talk about this today?	Y / N
Have you ever had a semen analysis done? If yes when?	Y/ N
Any past miscarriages or terminations?	Y/ N

OFFSPRING (please include dates and how conceived (naturally, IUIs, IVF)

PAST MEDICAL HISTORY
List all medical problems

PAST SURGICAL HISTORY
List all previous surgeries (please include dates)

MEDICATIONS
List all medications, vitamins, herbs or supplements with **dosage**

ALLERGIES
(Please include allergy/reaction)

SOCIAL HISTORY

Occupation?			
With whom do you live?			
Smoke?	Y/ N	If yes, how many packs a day?	
Drink alcohol?	Y/ N	If yes, how many drinks a week?	
Do drugs?	Y/ N	If yes, which drugs?	
International travel in the last 6-months?	Y/ N	Where and when	

FAMILY HISTORY-Please circle if you have any family members with the following:

☐Breast cancer ☐Uterine cancer ☐Ovarian cancer
☐Colon cancer ☐Stroke ☐High blood pressure
☐Heart attacks ☐Blood clots ☐Diabetes
☐Osteoporosis ☐Birth defects ☐High cholesterol

PREVENTATIVE What kind and how often?

Do you exercise?	Y / N		
Use sunscreen	Y / N	Seatbelt use?	Y / N

Have you had the following?		Please explain:
Testicular Trauma	Y / N	
Testicular Surgery	Y / N	
Erectile dysfunction	Y / N	
Ejaculatory dysfunction	Y / N	
Hernia	Y / N	
Other penile or scrotum issues	Y / N	

REVIEW OF SYSTEMS- Please circle if you have any of the following:

☐Fever ☐Cough
☐Fatigue ☐Shortness of breath
☐Hair loss ☐Chest pain
☐Feeling hot/cold ☐Palpitations
☐Weight loss/gain ☐Constipation
☐Breast pain ☐Diarrhea
☐Nausea/vomiting ☐Blood in stools
☐Pain with urination ☐Change in height
☐Blood in urine ☐Sleep difficulties
☐Loss of urine/incontinence ☐Depression or anxiety
☐Frequent urination ☐Rashes or skin lesions
☐Cuts that don't stop bleeding

NONE OF THE ABOVE