

MALE HEALTH HISTORY FORM
(Please Print Clearly)

Date: _____

Name: _____

DOB: _____

Reason for today's visit: _____

Height: _____ inches

Weight: _____ lbs Recent Gain: _____ Recent Loss: _____

Allergies (check all that apply and indicate reaction)

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Aspirin_____ | <input type="checkbox"/> Shellfish_____ | <input type="checkbox"/> Sulfa_____ |
| <input type="checkbox"/> Codeine_____ | <input type="checkbox"/> Betadine_____ | <input type="checkbox"/> None_____ |
| <input type="checkbox"/> Novocain_____ | <input type="checkbox"/> Latex_____ | <input type="checkbox"/> Other_____ |

Personal Medical History (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous / Mental Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Glaucoma/Eye Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Prostate Infection |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Redness/Pain in Leg |
| <input type="checkbox"/> Cancer / type:_____ | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Venereal Warts |

Surgical History (check all that apply)

- | | | | |
|---|-------------|---|-------------|
| <input type="checkbox"/> Appendix Operation | Date: _____ | <input type="checkbox"/> Penile Surgery | Date: _____ |
| <input type="checkbox"/> Coronary Artery Bypass | Date: _____ | <input type="checkbox"/> Prostate Surgery | Date: _____ |
| <input type="checkbox"/> Gallbladder Operation | Date: _____ | <input type="checkbox"/> Spinal Fusion | Date: _____ |
| <input type="checkbox"/> Hemorrhoid Operation | Date: _____ | <input type="checkbox"/> Testicular Surgery | Date: _____ |
| <input type="checkbox"/> Hernia Operation | Date: _____ | <input type="checkbox"/> Thyroid Operation | Date: _____ |
| <input type="checkbox"/> Hip | Date: _____ | <input type="checkbox"/> Tonsillectomy | Date: _____ |
| <input type="checkbox"/> Knee | Date: _____ | <input type="checkbox"/> Vasectomy | Date: _____ |

Other _____

Family History (check all that apply)

Does anyone in your immediate family – mother, father, siblings – have the following conditions(s):

- | | |
|--|---|
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Prostate Cancer _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Testicular Cancer _____ | <input type="checkbox"/> Thyroid Disorder _____ |
| <input type="checkbox"/> Cancer, other type _____ | |
| <input type="checkbox"/> Other _____ Explain _____ | |
| <input type="checkbox"/> Other _____ Explain _____ | |

Social History (check all that apply)

- Do you drink caffeinated products? No Yes How many drinks per day/month? _____
- Are you a smoker? No Yes Packs per day? _____ Years smoked? _____
- Are you a former smoker? No Yes Years smoked? _____ Year quit? _____
- Do you drink alcohol? No Yes How many drinks per day/month? _____
- Do you exercise? No Yes How many times per week? _____ What type? _____
- Do you use recreational drugs? No Yes

Have You Taken (check all that apply)

- | | | |
|--------------------------------------|-------------|---------------|
| <input type="checkbox"/> Viagra | Date: _____ | Result: _____ |
| <input type="checkbox"/> Cialis | Date: _____ | Result: _____ |
| <input type="checkbox"/> Levitra | Date: _____ | Result: _____ |
| <input type="checkbox"/> Other _____ | Date: _____ | Result: _____ |

Medical Tests (check all that apply)

- | | | |
|---|-------------|-----------------------------|
| <input type="checkbox"/> PSA (Blood test for prostate cancer) | Date: _____ | Abnormal or Elevated? _____ |
| <input type="checkbox"/> Digital Rectal Exam | Date: _____ | |
| <input type="checkbox"/> Colonoscopy | Date: _____ | |

Are there any other pertinent medical history concerns we should be aware of?

Name of any physicians familiar with your medical history:

Patient Signature

Date

Provider Initials

