Dr. Randolph's Ageless & Wellness Medical Center

C.W. Randolph, Jr., M.D. ● Lori Leaseburge, M.D. ● Nicole Thomas, ARNP ● ● Steven Garces, ARNP ● Kristin Byers, ARNP ●

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)

- ☐ Aspirin_____
- ☐ Codeine_____
- ☐ Novocain_____
- ☐ Shellfish_____
- ☐ Betadine_____
- ☐ Latex_____
- ☐ Sulfa_____
- ☐ None_____
- ☐ Other_____

Personal Medical History (check all that apply)

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

Surgical History (check all that apply)

- ☐ Appendix Operation Date: _____
- ☐ Coronary Artery Bypass Date: _____
- ☐ Gallbladder Operation Date: _____
- ☐ Hemorrhoid Operation Date: _____
- ☐ Hernia Operation Date: _____
- ☐ Hip Date: _____
- ☐ Knee Date: _____
- ☐ Penile Surgery Date: _____
- ☐ Prostate Surgery Date: _____
- ☐ Spinal Fusion Date: _____
- ☐ Testicular Surgery Date: _____
- ☐ Thyroid Operation Date: _____
- ☐ Tonsillectomy Date: _____
- ☐ Vasectomy Date: _____

Other _____

Family History (check all that apply)

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

- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Prostate Cancer_____
- ☐ Testicular Cancer _____
- ☐ Cancer, other type_____
- ☐ Diabetes_____
- ☐ Heart Disease_____
- ☐ Osteoporosis_____
- ☐ Thyroid Disorder
- ☐ Other _____ Explain _____
- ☐ 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)

- ☐ Viagra Date: _____ Result: _____
- ☐ Cialis Date: _____ Result: _____
- ☐ Levitra Date: _____ Result: _____
- ☐ Other _____ Date: _____ Result: _____

Medical Tests (check all that apply)

- ☐ PSA (Blood test for prostate cancer) Date: _____ Abnormal or Elevated? _____
- ☐ Digital Rectal Exam Date: ____ _____
- ☐ 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