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_________________
- ☐ Other ____________________ Explain ____
- ☐ Other ____________________ Explain ____
- ☐ Diabetes___________________________
- ☐ Heart Disease______________________
- ☐ Osteoporosis______________________
- ☐ Thyroid Disorder

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?

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Name of any physicians familiar with your medical history:

____

____

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Patient Signature　　　　　　　　　　Date　　　　　　　　　　Provider Initials