



MALE HEALTH HISTORY FORM

Today's Date: _____

Name: _____ DOB: _____

Previous Primary Care Physician: _____

Other physicians (specialists) involved in your care: _____

Preferred pharmacy: _____

MEDICAL HISTORY:

Have you been diagnosed with any of the following?

- Alcoholism, Allergies, Anemia, Anxiety, Arthritis, Asthma, Back pain, Blood clots, Cancer, Depression, Diabetes, Emphysema, Eye disease, Fractures, Gout, Migraines, Hearing loss, Heart attacks, Heart disease, Hepatitis, Hernia, High blood pressure, High Cholesterol, HIV, HPV infection, Incontinence, Insomnia, Kidney disease

- Kidney stones, Osteoporosis, Prostate enlargement, Stomach Reflux, Seizures, Sleep apnea, STDs, Stroke, Stomach ulcers, Thyroid disease, Testicular torsion, Urinary tract infections

Other medical history?

SURGICAL HISTORY:

Have you had any of the following?

- Abdominal surgery, Appendectomy, Brain surgery, Back surgery, Bladder surgery, Cosmetic surgery, Eye surgery, Gallbladder removal, Heart surgery, Hernia repair, Prostate surgery, Thyroid surgery, Vasectomy

Other surgical history?

ALLERGIES:

Are you allergic to any medications? Yes No

If yes, please list the name(s) and type of reaction

Table with 2 columns: NAME, REACTION

MEDICATIONS:

Do you currently take any prescription medications: Yes No

MEDICATION NAME	STRENGTH & DOSE	FREQUENCY
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed

Do you take any over-the-counter supplements? (Calcium, multivitamins, sleep aids, other supplements)

No Yes - _____

FAMILY HISTORY:

Unknown / Adopted

Family Member	Alcoholism	Breast Cancer	Colon cancer	Diabetes	Heart attack	Heart failure	High cholesterol	High blood pressure	Kidney disease	Lung cancer	Lupus	Mental illness	Ovarian cancer	Pancreatic cancer	Prostate cancer	Rheum. arthritis	Stroke	Thyroid disease
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paternal grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY:

Marital status: _____
 Occupation: _____
 Tobacco use Yes No
 Previously but quit: (date) _____
 Packs per day _____
 Years of use: _____ yrs
 Alcohol use Yes No
 If yes: # drinks / week _____
 Are you or others concerned about your drinking? Yes No
 Drug use Yes No
 If yes: type _____
 Do you practice any religion Yes No
 If yes, which one? _____
 Do you exercise? Yes No
 How often? _____ times/week
 What type of exercise? _____

HEALTH MAINTENANCE:

If you've had any of the following please specify date last performed:

Prostate exam _____
 PSA _____
 Colonoscopy _____
 Aortic aneurysm screening _____
 CT for lung cancer screening _____
 Dental exam _____
 Eye exam _____
 Tetanus shot _____
 HPV series (3) _____
 Flu shot _____
 Pneumonia shot _____
 Shingles vaccine _____
 Hepatitis A vaccine _____
 Hepatitis B vaccine _____
 Meningitis vaccine _____