<p><strong>MALE MEDICAL HISTORY</strong></p>

This information is confidential and will be used by your medical provider to make sure you get proper care.

- Are you allergic to any medications? List here:
  - Yes
  - No

- Do you take any over the counter medicines, prescription medicines, vitamins, supplements, or home remedies? List here:
  - Yes
  - No

- Do you have a usual source of primary care? If yes, who?

### A. Family Medical History:

Has anyone in your family (mother, father, brother, sister) ever had:

- Heart attack/disease
- Stroke
- Blood clot in legs/lungs
- High blood pressure
- High cholesterol
- Diabetes
- Alcohol or drug abuse
- Birth defects/genetic problems
- Mental illness
- Maternal DES exposure
- Cancer
- Blood clot in legs/lungs
- Maternal DES exposure
- I do not know my family problems

### B. Personal Medical History:

1. Have you ever had problems with any of these? Check all that apply.

   - Heart disease
   - High blood pressure
   - Stroke
   - Diabetes
   - High cholesterol
   - Tuberculosis (TB)
   - Asthma
   - Blood clot in legs/lungs
   - I never had a genial exam
   - Bleed/bruise easily
   - I never had sex

   - Anemia
   - Sickle cell disease
   - Kidney/bladder problems
   - Seizures or epilepsy
   - Depression
   - Mental illness
   - Severe headaches or migraines
   - Severe headaches or migraines
   - I never had a genial exam

   - Liver problems or hepatitis
   - Gall bladder disease
   - Eating disorder
   - Cancer
   - Type:
   - Thyroid disease
   - Infertility

2. Have you ever been hospitalized or had any surgery? If yes, when and why?

3. Have you ever had a transfusion or blood exposure? If yes, when and why?

4. Have you been immunized against rubella? If yes, when was your last one?
   - I do not know

5. Have you been immunized against hepatitis B? If yes, when was your last one?
   - I do not know

6. When was your last genital exam? If yes, when was your last one? Was it:
   - Positive
   - Negative

7. Have you ever had an HIV test? If yes, when was your last one?

### C. Contraception History:

1. How old were you when you first had intercourse? ___ years old

2. How important is it for you to avoid pregnancy now? Very

3. What birth control methods have you and your partner(s) used in the past? None

   - Condoms/rubbers
   - Birth control pills
   - DepoProvera/shot
   - Patch
   - NuvaRing (vaginal ring)

4. What birth control are you and your partner(s) currently using? None

5. Are you happy with your method?

6. How often do you use condoms? Always

7. Have you ever used emergency contraception (morning after pill/Plan B)?

8. Have you ever gotten anyone pregnant? Unsure

9. Are you and your partner planning to get pregnant in the next two years?

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D. Habit and Lifestyle:

If you prefer, you can talk to your health care provider about these important questions.

1. How many glasses of an alcoholic beverage do you have per week? __________  ❑ None
2. ❑ Yes ❑ No  Do you smoke cigarettes?  If yes, how many cigarettes per day? ______________
3. ❑ Yes ❑ No  Do you use street drugs?  If yes, please list:______________________________
4. ❑ Yes ❑ No  Have you ever used injected drugs?
5. ❑ Yes ❑ No  Have you ever shared needles?
6. ❑ Yes ❑ No  Has anyone ever told you that you have a problem with drugs or alcohol?
7. ❑ Yes ❑ No  Is anyone, including your partner, threatening you, causing you to be afraid, or hurting you physically?
8. ❑ Yes ❑ No  Have you ever been pressured or forced to have sex when you did not want to?
9. Have you ever had a sex partner with a history of:  ❑ Injected drug use  ❑ HIV

E. Sexual History:

In the last 12 months...

1. ❑ Yes ❑ No  Have you been sexually active?  If no, skip to #6.
   If yes, how many sexual partners have you had? __________
2. Have you had sex with:  ❑ Men  ❑ Women  ❑ Both?
3. Have you and/or your partner(s) had:  ❑ Oral sex  ❑ Anal sex  ❑ Vaginal sex?
4. ❑ Yes ❑ No  Have you traded sex for money or drugs?
5. Do you think that your partner has other sexual partners?
   ❑ Yes, definitely   ❑ Not sure, possibly   ❑ No, very unlikely
6. In the last 12 months have you or your sex partner(s) had any of the following:
   A. ❑ Chlamydia  D. ❑ Trichomoniasis (Trich)  G. ❑ Syphilis
   B. ❑ Gonorrhea  E. ❑ Pelvic Inflammatory Disease  H. ❑ Other:______________________________
   C. ❑ Genital Herpes  F. ❑ Genital warts
7. ❑ Yes ❑ No  Is there anything else about your health or sexual practices that you would like to discuss with your clinician?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

_________________________________  _____________________________
Patient Signature/Date                  Clinician Signature/Date

_________________________________  _____________________________
Clinician Signature/Date Updated        Clinician Signature/Date Updated