MALE PATIENT HISTORY SHEET

PATHWAY Health Clinic

LEGAL NAME_____ DATE _____/_____/_____

BIRTH DATE____/_____/_____ CLIENT #_____

*MAJOR MEDICAL CARE IN THE PAST YEAR?_____ *WHO IS YOUR PRIVATE DOCTOR?_____

***CHIEF COMPLAINT:**_____

***MEDICATION ALLERGIES:** _____

_____

***CURRENT MEDICATIONS:**_____

_____

***TRAVEL**

In the last 30 days, have you traveled outside the U.S.? YES ___ NO ___

***VACCINE HISTORY AND DATES**

YES	NO	
		Tetanus
		Hepatitis B
		Hepatitis A
		Gardasil
		Rubella (German Measles)

***MEDICAL HISTORY**

FAMILY MEMBERS

YES	NO	
		Diabetes
		High Blood Pressure
		Epilepsy
		Migraine Headaches
		Cancer
		Heart Attack before age 50
		Genetic problems
		Maternal exposure to DES
		High cholesterol
		Sickle cell anemia

***CONTRACEPTIVE HISTORY**

Methods of birth control used:

	condoms
	withdrawal
	Nat. Family Plng.
	Vasectomy
	None, trying for pregnancy

Problems with any of these methods:

_____

What method do you want to use now with your current partner(s)?

_____

Have you fathered any children?_____

***SEXUAL HISTORY**

Age of first intercourse?_____

Are you currently sexually active?

YES___ NO___

When was your last sexual encounter?

_____

Have you had more than one sex partner during your life? YES____ NO ____

Approximately how many?_____

In the past 3 months, how many people have you had sex with? _____

In the past 12 months, how many people have you had sex with? _____

Do you have sex with:

Men Women Both

Do you have vaginal sex?

Yes No

Do you have anal sex?

Give Receive or NO

Do you have oral sex?

Give Receive

***RISK EXPOSURE INFORMATION**

YES	NO	
		Homo/Bisexual
		IV Drug User
		Hemophilia
		Prostitute
		Trade Sex for Drugs
		Sex Partner of Homo/Bisexual
		Sex partner of IV Drug User
		Sex Partner with AIDS/HIV+
		Has anyone requested sexting or nude pictures of you?
		Have you had sex while drinking alcohol?
		Had sex with someone you don't know?
		Had sex with someone you met over the internet?

***PAST STD HISTORY**

YES	NO	
		Have you been tested/treated for an STD in the past 12 months?
		Gonorrhea/Chlamydia/Trich/Warts Herpes or Syphilis
		Has your partner(s) been tested/ treated for any STD in the past 12 mo?
		Gonorrhea/Chlamydia/Trich/Warts Herpes or Syphilis
		Have you ever had or been told you had hepatitis?
		Have you taken any antibiotics for infection recently?
		Have you ever had an HIV test? If so, Pos or Neg

***PROTECTION FOR STD's**

How do you protect yourself/partner from STD's and HIV/AIDS?

_____

How often do you use condoms?

Always Sometimes Never

***SIGNS/SYMPTOMS**

YES	NO	
		Unusual discharge from penis?
		Itching or burning with urination?
		Unusual bleeding after sex?
		Bumps or sores on/around your penis?
		Itching or burning in your genital area?
		Pain with intercourse?

***HOSPITAL/SURGICAL HISTORY**

_____

***REPRODUCTIVE LIFE PLAN**

Do you plan to have children (more) ? _____

If your partner becomes pregnant, you plan to: _____

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***HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?**

YES	NO		YES	NO	
		Surgeries/Hospitalizations			Do you smoke cigarettes, use street drugs, tobacco or alcohol? If yes, specify amount. _____
		Anemia/Sickle Cell Anemia/Immune Disorders/Lupus			
		Asthma/Respiratory Problems			
		Bladder problems/Infections/Kidney Infections			Sexual Abuse (Actual or potential) You /children
		Blood clots in veins/varicose veins			
		Blood transfusion prior to 1993			Domestic Violence (Actual or potential) You/Children
		Breast disease/Lump/Nipple discharge			
		Cancer			Are you afraid of your partner or any family member?
		Depression/Emotional problems			Have you been forced into sex or sexual activities?
		Diabetes			
		Eating disorders: obesity, anorexia, bullimia			Have you been hit, slapped, punched, shoved, kicked, etc?
		Epilepsy			
		Frequent or severe headaches/migraines			
		Gall bladder problems/Infections			
		Genetic problems			
		Heart Attack before age 50			
		Heart problems/murmurs/High blood pressure			
		Hepatitis/liver problems			
		High Cholesterol			
		Intestinal/Stomach problems			
		Maternal exposure to DES			
		Mononucleosis			
		Thyroid problems			
		Substance abuse			
		VD/Gonorrhea/Syphillis/Herpes			
		Warts/Chlamydia			
		Vision problems			
		Hearing problems			

ASSURANCE OF CONFIDENTIALITY:

This medical record is confidential and will not be released to anyone without your consent except as may be required by law.

Signature:_____

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE

Staff reviewed _____[initials]

Clinician reviewed _____[initials]