

Family Health Care, Inc.

Male Health History

Allergies and Current

Medication: Ever had a reaction to any drug, medication, including local anesthesia?

Y N

If yes, Name: _____

Do you currently take medicine?

Y N

If yes, Name: _____

Personal Medical History

Do you now or have you ever had disease of:

Circle

- Y N Heart
- Y N Gallbladder/Live
- Y N Nerves/Depression
- Y N Stomach/Bowel
- Y N Blood Pressure
- Y N Cancer
- Y N Headaches
- Y N Diabetes
- Y N Fainting
- Y N Seizure
- Y N Skin/Bones
- Y N Joints
- Y N Lungs/Asthma/TB
- Y N Elevated Cholesterol
- Y N Kidneys/Bladder

When was your last Tetanus shot? Date: _____

Family History

Circle

- | | Relation |
|-----|---------------------|
| Y N | Diabetes |
| Y N | Heart Attack |
| Y N | Stroke before 60 |
| Y N | High Cholesterol |
| Y N | High Blood Pressure |
| Y N | Birth Defects |
| Y N | Genetic Problems |

- Y N Cancer
- Y N Prostate cancer
- Y N Testicular cancer
- Y N Exposed to Lead?

Circle

Y N Are you having sex?

Have you experienced recently:

- Y N Constipation
- Y N Diarrhea
- Y N Emotional Changes
- Y N Penis Discharge
- Y N Penis Itching

Have You Been Treated For:

- Y N Gonorrhea
- Y N Chlamydia
- Y N Genital Herpes
- Y N Genital Warts
- Y N Syphilis

When? _____

Social History

Highest grade completed: _____

Have you recently experience:

Circle

- Y N Emotional/Relationship Changes?
- Y N Death of a family Member/Friend?
- Y N Job Loss/Financial Problems?
- Y N Problems with Living Arrangements/School?
- Y N Legal Problems/Arrest/Divorce?
- Y N Parental Problems?

Y N Has anyone Forced You to have sex?

Y N Has anyone hit, Slapped, kicked, or Hurt you?

Y N Are You Afraid of Your Partner/Family Member?

Y N Do You Have Someone that supports You with Your Problems?

Y N Are You on a Special Diet?

Y N Do You Smoke?

Number of Cigarettes _____

Y N Do You Drink Alcoholic Drinks?

Number Per Week _____

Y N Have you changed Partners in the last 6 Months?

Y N Have you used street Drugs?

Type: _____

When: _____

Were any of your partners a street drug user, Hemophilic, or infected with HIV/AIDS or Hepatitis?

Y N

Age first intercourse? _____

Do you have:

- Oral Sex
- Vaginal Sex
- Anal Sex

How many different people have you had sex with?

Male _____

Female _____

Do you use condoms? Y N

Please check one:

- African American
- White(Not Hispanic Origin)
- Hispanic
- Asian/Pacific Islander
- Amer. Indian/Alaskan Native

HOSPITALIZATIONS AND SURGERIES

DATE	REASON

Signature

Date