

MALE SELF-HISTORY

Today's Date: _____

PLEASE PRINT!

Name: _____ DOB: _____ Age: _____

I am a: new patient established patient

If new, how did you hear about us? Family/friend Yellow pages Internet Newspaper Other

Date of last tetanus vaccination: _____ Flu vaccination: _____ Shingles vaccination: _____

Drug Allergies: _____

Fun Facts

Favorite Childhood Memory: _____

Favorite Song: _____

Favorite thing to drink (Coffee/tea/etc.): _____

Please list any medications you are taking – prescription and over the counter—YOU MAY ATTACH A LIST

Check if refill needed:

<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____

Name of pharmacy you plan to use: _____ Address: _____

Reason for visit today: _____

Medical History:

Please check if you currently or have ever had any of the following:

<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Cancer, if yes, list type: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Thyroid	<input type="checkbox"/> High Blood Pressure
		<input type="checkbox"/> High Cholesterol

Other medical problems not listed above: _____

Please list any surgical procedures you have had:

Social History:

Are you: single married divorced widowed single but in long-term relationship

Are you currently sexually active? Y N Any new partners since your last exam? Y N

Are you interested in getting tested for sexually transmitted diseases? Y N

Patient Name _____ DOB _____

What is your current occupation? _____

Do you smoke? Y N If yes, how much? _____

If no, did you ever smoke? Y N If yes, how much & when did you quit? _____

How often do you use alcohol? Never Rarely 2-3 times a month 2-3 times a week Daily

Do you use any recreational drugs? Y N If yes, what kind? _____

Do you exercise? Y N If yes, how often and what type? _____

Family Medical History:

(Indicate who has problem: M-Mother F-Father GM-Grandmother GF-Grandfather B-Brother S-Sister)

Allergies	_____	Heart disease/Stroke	_____	Seizures	_____
Arthritis	_____	High blood pressure	_____	Vision/Hearing Problems	_____
Blood disorder/Sickle cell	_____	Kidney/Liver disease	_____	Ulcers/Colitis	_____
Cancer	_____	Lung disease	_____	Urinary/Bowel problems	_____
Diabetes	_____	Mental illness	_____	Blood Clots	_____
Drug/alcohol abuse	_____	Obesity	_____	Other	_____

Please circle if you are having any of the following problems:

EYES: vision changes discharge irritation sensitivity to light

ENT: hearing problem ear pain runny nose congestion sneezing hoarseness sore throat sinus pain

Resp: shortness of breath cough wheezing coughing blood

Cardiac: chest pain irregular heartbeat fainting swelling murmur

GI: nausea vomiting bloating diarrhea heartburn abdominal pain blood in stool change in stools

GU: frequent urination incontinence blood in urine pain with urination

Muscular: back pain neck pain joint stiffness joint swelling muscle pain

Neuro: weakness dizziness seizures headaches loss of consciousness

Skin/Breast: rash concerning skin lesions breast problems

Psych: nervousness mood changes depression problems sleeping

Endocrine: hair loss heat or cold intolerance excessive body hair increased thirst frequent urination

Heme: easy bruising swollen nodes abnormal bleeding

Allergy: environmental allergies immune deficiency

Health Maintenance:

Date of last cholesterol screening: _____ Results: normal abnormal don't know

Date of last diabetes screening: _____ Results: normal abnormal don't know

Date of last colonoscopy: _____ Results: normal abnormal don't know