



Name _____ Date _____

Chart # _____ Date of Birth _____

MALE MEDICAL HISTORY

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

Yes No 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:

- | | | |
|--|--|--|
| 1. <input type="checkbox"/> Heart attack/disease | 5. <input type="checkbox"/> High cholesterol | 9. <input type="checkbox"/> Cancer |
| 2. <input type="checkbox"/> Stroke | 6. <input type="checkbox"/> Diabetes | 10. <input type="checkbox"/> I do not know my family medical history |
| 3. <input type="checkbox"/> Blood clot in legs/lungs | 7. <input type="checkbox"/> Alcohol or drug abuse | |
| 4. <input type="checkbox"/> High blood pressure | 8. <input type="checkbox"/> Birth defects/genetic problems | |

Provider notes:

B. Personal Medical History:

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

- | | | |
|--|---|---|
| A. <input type="checkbox"/> Heart disease | J. <input type="checkbox"/> Anemia | R. <input type="checkbox"/> Liver problems or hepatitis |
| B. <input type="checkbox"/> High blood pressure | K. <input type="checkbox"/> Sickle cell disease | S. <input type="checkbox"/> Gall bladder disease |
| C. <input type="checkbox"/> Stroke | L. <input type="checkbox"/> Kidney/bladder problems | T. <input type="checkbox"/> Eating disorder |
| D. <input type="checkbox"/> Diabetes | M. <input type="checkbox"/> Seizures or epilepsy | U. <input type="checkbox"/> Cancer |
| E. <input type="checkbox"/> High cholesterol | N. <input type="checkbox"/> Depression | Type: _____ |
| F. <input type="checkbox"/> Tuberculosis (TB) | O. <input type="checkbox"/> Suicidal thoughts | V. <input type="checkbox"/> Thyroid disease |
| G. <input type="checkbox"/> Asthma | P. <input type="checkbox"/> Mental illness | W. <input type="checkbox"/> Infertility |
| H. <input type="checkbox"/> Blood clot in legs/lungs | Q. <input type="checkbox"/> Severe headaches or migraines | X. <input type="checkbox"/> Difficulty with urination |
| I. <input type="checkbox"/> Bleed/bruise easily | | |

2. Yes No Have you ever been hospitalized or had any surgery? If yes, when and why? _____

3. Yes No Have you ever had a transfusion or blood exposure?

4. Yes No Have you been immunized against hepatitis B? I do not know

5. When was your last genital exam? _____ I never had a genital exam

Yes No Were you ever told there was any problem? If yes, what? _____

6. Yes No Have you ever had an HIV test? If yes, when was your last one? _____ Was it: Positive Negative?

C. Contraception History:

1. How old were you when you first had intercourse? ____ years old I never had sex

2. How important is it for you to avoid fathering a child now? Very Somewhat Not at all

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

- | | |
|---|--|
| A. <input type="checkbox"/> Condoms/rubbers | C. <input type="checkbox"/> Withdrawal/pulling out |
| B. <input type="checkbox"/> Relied on partners method | D. <input type="checkbox"/> Vasectomy |

4. What birth control are you currently using? None

5. Yes No Are you happy with your method?

6. How often do you use condoms? Always Sometimes Never

7. Yes No Do you know about the emergency contraception pill?

8. Yes No Have you ever gotten anyone pregnant? Unsure

9. Yes No Maybe Are you and your partner planning to get pregnant in the next two years?



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D. Social History:

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 Sex with men 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. <input type="checkbox"/> Chlamydia	D. <input type="checkbox"/> Trichomoniasis (Trich)	G. <input type="checkbox"/> Bacterial vaginosis (BV)
B. <input type="checkbox"/> Gonorrhea	E. <input type="checkbox"/> Pelvic Inflammatory Disease	H. <input type="checkbox"/> Syphilis
C. <input type="checkbox"/> Genital Herpes	F. <input type="checkbox"/> Genital warts	I. <input type="checkbox"/> Other: _____
7. Yes No Is there anything else about your health or sexual practices that you would like to discuss with your clinician?

F. IF YOU ARE UNDER 18 YEARS OF AGE

8. Yes No Are your parents aware of your visit to Planned Parenthood?
9. Yes No Do you talk to your parents about sexuality issues?

Provider notes:

Patient Signature/Date

Clinician Signature/Date