MALE MEDICAL HISTORY

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Referred By:_____ Marital Status:_____

Name of Primary Care Provider (PCP): _____

Current/Past Specialty Providers: _____

List your top 3 concerns for today's visit:

_____

_____

_____

Allergic To:	Reaction

Allergic to: Latex: ☐ Yes ☐ No Lidocaine: ☐ Yes ☐ No Betadine: ☐ Yes ☐ No

Medication	Dose	Reason for taking	Prescriber

Preferred Pharmacy: _____ **Address:** _____ **Phone:** _____

Past Medical History:

_____

_____

_____

_____

Tobacco Use circle one, add details if needed

☐ **Has never smoked tobacco**

☐ **Former Smoker:** Year quit _____ Years smoking _____ Packs per day: ☐ ½ ☐ 1 ☐ 1½ ☐ 2

☐ **Current Smoker:** Desire Quitting? ☐ Yes ☐ No Years smoking _____ Packs per day: ☐ ½ ☐ 1 ☐ 1½ ☐ 2

Alcohol use:

Do you drink alcohol? ☐ Yes ☐ No if yes, how many drinks per week? _____

Do you have previous or current problems with alcohol? _____

Substance abuse:

Recreational drug use? ☐ Yes ☐ No Details _____

Prescription drug abuse? ☐ Yes ☐ No Details _____

GU History (Male):

History of impotence, BPH, prostate cancer or testicular cancer? If so please explain:

_____

_____

Any current or previous treatments with hormones? YES/NO If yes, describe including positive or negative effects_____

_____

_____

Preventative Health History: Please enter dates of most recent and details if abnormal.

Preventative Test	Date	Normal	Abnormal	History of Abnormal Details
Colonoscopy				
Rectal Exam				
PSA				
Chest X-Ray				
EKG				
Exercise Stress Test				

Tetanus Vaccine: _____ Flu Vaccine: _____ Pneumonia Vaccine: _____

Tuberculosis Test: _____ Hepatitis Vaccine: _____ HIV Test: _____

Surgical and Hospitalization History:

_____

_____

_____

Family History:

List family members with the following health conditions. Please circle if cause of death.

- ☐ Heart Disease: _____
- ☐ Heart Attack before age 50: _____
- ☐ High Blood Pressure: _____
- ☐ Diabetes: _____
- ☐ Thyroid Disorder: _____
- ☐ Mental Illness: _____
- ☐ Genetic Disorder: _____
- ☐ Breast Cancer: _____
- ☐ Ovarian Cancer: _____
- ☐ Colon Cancer: _____
- ☐ Other: _____

REVIEW OF SYSTEMS (ROS): circle all that apply

CONSTITUTIONAL: chills, fatigue, fever, weight change

EYES: blurred vision, eye pain, photophobia

E/N/T: hearing problems, congestion, rhinorrhea, epistaxis, dental problems

CARDIOVASCULAR: chest pain, palpitations, fast heart rate, shortness of breath, edema

RESPIRATORY: cough, painful breathing, coughing blood

GASTROINTESTINAL: abdominal pain, heartburn, constipation, diarrhea, stool changes

GENITOURINARY: genital lesions, blood in urine, urinary frequency, painful urination, decreased libido

MALE: erections less strong, difficulty urinating

MUSCULOSKELETAL: joint pain, back pain, muscle aches, decrease in strength or endurance, loss of height

INTEGUMENTARY/BREAST: atypical moles, dry skin, itching, rashes, breast mass, nipple discharge

NEUROLOGICAL: dizziness, headaches, numbness/tingling, weakness

HEMATOLOGIC/LYMPHATIC: easy bruising, easy bleeding (not due to medication), swollen lymph nodes

ENDOCRINE: hair loss, heat/cold intolerance, excessive thirst, excessive hunger, hot flashes, night sweats

ALLERGIC/IMMUNOLOGIC: allergies, frequent illnesses, HIV exposure, hives

PSYCHIATRIC/SLEEP: anxiety, depression, sleep disturbances, mood changes, irritability

Patient's Signature: _____ **Date:** _____