

**MALE HEALTH HISTORY FORM**  
(Please Print Clearly)

Date: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**Personal Medical History (check all that apply)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Gonorrhea                 | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Arthritis/Gout       | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Prostate Cancer      |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Prostate Infection   |
| <input type="checkbox"/> Blood Transfusion    | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Prostatitis          |
| <input type="checkbox"/> Blurred Vision       | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Herpes                    | <input type="checkbox"/> Redness/Pain in Leg  |
| <input type="checkbox"/> Cancer / type: _____ | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Kidney/Bladder Problems   | <input type="checkbox"/> Shortness of Breath  |
| <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Chlamydia            | <input type="checkbox"/> Lung Disease              | <input type="checkbox"/> Syphilis             |
| <input type="checkbox"/> Colitis              | <input type="checkbox"/> Measles                   | <input type="checkbox"/> Thyroid Problem      |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Migraines                 | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Mononucleosis             | <input type="checkbox"/> Ulcer                |
| <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Mood Changes              | <input type="checkbox"/> Varicose Veins       |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Mumps                     | <input type="checkbox"/> Venereal Warts       |
| <input type="checkbox"/> Gallbladder Disease  | <input type="checkbox"/> Nervous / Mental Disorder |   |
| <input type="checkbox"/> Glaucoma/Eye Disease | <input type="checkbox"/> Phlebitis                 |   |

**Allergies (check all that apply)**

- |                                      |                                  |                                   |
|--------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Codeine | <input type="checkbox"/> Novocain |
| <input type="checkbox"/> Betadine    | <input type="checkbox"/> Latex   | <input type="checkbox"/> Sulfa    |
| <input type="checkbox"/> Shellfish   |                                  |                                   |
| <input type="checkbox"/> Other _____ |                                  |                                   |

**Weight**

Usual: \_\_\_\_\_ Recent Gain: \_\_\_\_\_ Recent Loss: \_\_\_\_\_

**Have You Taken (check all that apply)**

Viagra (Date: \_\_\_\_\_) Result: \_\_\_\_\_

Cialis (Date: \_\_\_\_\_) Result: \_\_\_\_\_

Levitra (Date: \_\_\_\_\_) Result: \_\_\_\_\_

Other \_\_\_\_\_ (Date: \_\_\_\_\_) Result: \_\_\_\_\_

**Medical Tests (check all that apply)**

PSA (Blood test for prostate cancer) (Date: \_\_\_\_\_) Abnormal or Elevated? \_\_\_\_\_

Digital Rectal Exam (Date: \_\_\_\_\_)

Colonoscopy (Date: \_\_\_\_\_)

Cholesterol (Date: \_\_\_\_\_)

**Surgical History (check all that apply)**

Appendix Operation (Date: \_\_\_\_\_)  Prostate Surgery (Date: \_\_\_\_\_)

Gallbladder Operation (Date: \_\_\_\_\_)  Testicular Surgery (Date: \_\_\_\_\_)

Hemorrhoid Operation (Date: \_\_\_\_\_)  Thyroid Operation (Date: \_\_\_\_\_)

Hernia Operation (Date: \_\_\_\_\_)  Tonsillectomy (Date: \_\_\_\_\_)

Penile Surgery (Date: \_\_\_\_\_)  Varicose Vein Operation (Date: \_\_\_\_\_)

Other \_\_\_\_\_

**X-Rays (check all that apply)**

Chest  Lower GI  Skull

Stomach/Esophagus  Gallbladder  Colon

Upper GI  Kidneys

**Social History (check all that apply)**

Do you drink caffeinated products?  No  Yes How many drinks per day/month? \_\_\_\_\_

Are you a smoker?  No  Yes Packs per day? \_\_\_\_\_ Years smoked? \_\_\_\_\_

Do you drink alcohol?  No  Yes How many drinks per day/month? \_\_\_\_\_

Do you exercise?  No  Yes How many times per week? \_\_\_\_\_ What type? \_\_\_\_\_

Do you use drugs?  No  Yes

**Family History (check all that apply)**

Does anyone in your immediate family – mother, father, siblings – have the following conditions(s):

| <u>Condition</u>                            | <u>Whom</u>         |
|---|---------------------|
| <input type="checkbox"/> Breast Cancer      | _____               |
| <input type="checkbox"/> Colon Cancer       | _____               |
| <input type="checkbox"/> Prostate Cancer    | _____               |
| <input type="checkbox"/> Testicular Cancer  | _____               |
| <input type="checkbox"/> Cancer, other type | _____               |
| <input type="checkbox"/> Diabetes           | _____               |
| <input type="checkbox"/> Heart Disease      | _____               |
| <input type="checkbox"/> Osteoporosis       | _____               |
| <input type="checkbox"/> Thyroid Disorder   | _____               |
| <input type="checkbox"/> Other              | _____ Explain _____ |
| <input type="checkbox"/> Other              | _____ Explain _____ |

Are there any other pertinent medical history concerns we should be aware of?

\_\_\_\_\_  
\_\_\_\_\_

Name of any physicians familiar with your medical history:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Initials