MALE - MEDICAL HEALTH HISTORY

This medical record is confidential and will not be released to anyone except as may be required by law.

Oneida Count Reproductive Health Clinic
100 W Keenan St
Rhinelander WI 54501
Phone: 715-369-6116 Fax: 715-369-2553

Client Name:__________________
Client No.____________________
Date: ______/______/________

Name:____ Date of Birth _____/_____/________ Age ________
(Last) (First) (MI) mm / dd / yyyy
Please call me (preferred name) ___________________________________ Preferred gender: He___ She___ Other: _____ Reason for visit___
Have you or your partner recently traveled to a region with known Zika or Ebola transmission? ___Yes ___No If yes, where: ________________

Please check if you are allergic to:
❑ Penicillin ❑ Zithromax ❑ Doxycycline ❑ Sulfa ❑ Amoxicillin ❑ Local anesthetic
❑ Metal ❑ Rocephin ❑ Tetracycline ❑ Latex ❑ Iodine
Other(s): ___________________________________ ❑ No Allergies
List medications, vitamins, over the counter drugs, and/or herbs you take:____
Have you recently taken antibiotics _____ Yes _____No If yes, when?: ____________ for what?:____________what kind?:_______________

SEXUAL HISTORY

Have you ever had sex? ____Yes ____ No
Are you currently sexually active ____ Yes _____No If Yes, when was the last time you had sex?:___________
Have you or your partner had more than one sex partner in your lifetime? ____ Yes ____ No
Have you ever engaged in a sexual activity where you felt you couldn't say no? ____Yes ____ No
Have you or your partner had a new partner in the past 90 days? ____Yes ___No ___Don't know
Have you or your partner had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days?____ Yes ____ No ___ Don't know
Have you or your partner(s) used IV drugs? ___Yes ___ No ____ Don't know
Check if you have: ___ vaginal sex ___ oral sex ___ anal sex ___sex with men ___sex with women ___sex with both
Check if your partner has: ___vaginal sex ___oral sex ___anal sex ___sex with men ___ sex with women ___ sex with both
Check if you have ever had: ___ Chlamydia ___ Gonorrhea ___ HPV/warts ___ Herpes ___ Syphilis
Do you use condoms? ____Yes, every time ____No ____Sometimes
Has anyone ever messed with your condom before or during sex? ____Yes ____No
Does your partner use birth control? ____Yes ____No ____ I don't know
Are you and your sexual partner(s) in agreement about pregnancy prevention and birth control? ___Yes ___No
Are you circumcised? ____Yes _____ No _____I don't know

REPRODUCTIVE LIFE PLAN

Do you hope to have any (more) children? ____ Yes ____ No
How many children do you hope to have? _________________
When would you plan your child/children? ____
What do you plan to do until you (and your partner) are ready to have a baby? ____
What can I do today to help you achieve your plan? ____

SOCIAL HISTORY

Do you smoke/chew tobacco? ____ Yes ____ No If, YES, _____# per day Do you want to quit? ____Yes ____ No
Do you drink alcohol? ____Yes ____No Do you use street drugs? ____Yes ____ No
Do you use steroids/performance enhancing drugs? ____Yes ____No
Does alcohol/drugs cause problems in your life and/or are others concerned? ____Yes ____ No
Do you feel threatened or afraid of someone in your life? _____ Yes ____ No
Check if you have any concerns about: ____ Date rape _____ Forced/unwanted sex _____ Physical abuse _____Weight
Have you ever received medical care/medications for your mental health? ____Yes ____ No

PAST MEDICAL HISTORY:

Have you ever been in the hospital? ____Yes ____ No If yes, why ___________________________________
Do you have a doctor? ____Yes ____ No If yes, Doctor's name : __________________________________
List any medical problems: ____
Name of last medical clinic that you visited: ____________________________

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Do you now have or have you ever had:

Yes	No		Yes	No		Yes	No	
___	___	Anemia	___	___	Gall Bladder disease	___	___	Sickle cell anemia, trait of Thalassemi
___	___	Asthma	___	___	Genetic condition	___	___	Stroke
___	___	Breast Surgery or disease	___	___	Heart Disease/High blood pressure	___	___	Thrombophlebitis / blood clot(s)
___	___	Cancer	___	___	High Cholesterol	___	___	Tuberculosis
___	___	Diabetes	___	___	Mono or Hepatitis	___	___	Testicle growth/lump/surgery
___	___	Diagnosis w/HIV/AIDS	___	___	Mitral Value Prolapse (MVP)	___	___	Infection in testicles, scrotum or prostate.
___	___	Blood disorders/Problems with your blood	___	___	Seizure disorder / epilepsy	___	___	Undescended testicle
			___	___	Bariatric surgery			

FAMILY HISTORY

If you are adopted and do not know your family's medical history- go to next section.
Does your mother, father, brother, or sister have any of the following:

Stroke ___Yes ___ No
Heart Attack ___ Yes ___ No
Blood Clot ___ Yes ___ No
Diabetes ___ Yes ___ No
High Cholesterol ___ Yes ___ No
High Blood Pressure ___ Yes ___ No
Ovarian Cancer ___ Yes ___ No
Breast Cancer ___ Yes ___ No
Prostate Cancer ___ Yes ___ No
Colorectal Cancer ___ Yes ___ No
Testicular Cancer ___ Yes ___ No

REVIEW OF SYSTEMS

A. General
Yes No
___ ___ Recent weight gain or loss (+25 lbs)
___ ___ Reactions to drugs or foods

B. Cardiovascular
Yes No
___ ___ Chest Pain
___ ___ Palpitations
___ ___ Varicose Veins

C. Genitourinary
Yes No
___ ___ Pain or burning with urination
___ ___ Frequent/ difficult urination
___ ___ Discharge, itching, irritation, odor from penis
___ ___ Bumps rash, sores on penis, groin or scrotum
___ ___ Blood in urine
___ ___ Have you urinated in past hour?
___ ___ Pain in testes or scrotum
___ ___ Pain or bleeding with sex or ejaculation

D. Musculoskeletal
Yes No
___ ___ Muscle or bone pain/weakness
___ ___ Back pain

E. Skin
Yes No
___ ___ Acne
___ ___ Rash/itching
___ ___ Night sweats/ fever/ chills
___ ___ Other skin problems

F. Breasts
Yes No
___ ___ Breast lump
___ ___ Breast pain
___ ___ Nipple discharge

G. Eye, Ears, Nose, Throat
Yes No
___ ___ Hearing problems
___ ___ Frequent nose bleeds
___ ___ Frequent sore throat
___ ___ Thyroid problems
___ ___ Blurred vision/double vision

H. Respiratory
Yes No
___ ___ Chronic cough
___ ___ Shortness of breath/ breathing problems

I. Neuro/Psych
Yes No
___ ___ Headaches
___ ___ Convulsions / Seizures
___ ___ Difficulty with memory or speech
___ ___ Emotional problems
___ ___ Sadness
___ ___ Nervousness
___ ___ Numbness/tingling

J. Gastrointestinal
Yes No
___ ___ Abdominal pain
___ ___ Nausea/vomiting
___ ___ Changes in bowel habits
___ ___ Changes in appetite
___ ___ Rectal pain or bleeding
___ ___ Constipation/ diarrhea

K. Immunizations (check all you've had)
❑ Tetanus ❑ Hepatitis A ❑ Pertussis ❑ Gardasil/HPV
❑ Hepatitis B ❑ Meningococcal ❑ Chicken Pox
❑ Mumps / Measles / Rubella

DIET & EXERCISE

of servings of the following/per day: ____Dairy ___ Protein ____ Vegetables ____ Fruits ___ Grains
How many meals do you eat a day?__________ How much coffee, tea and soda per day?________________
What do you do for physical activity?________________________ How many hours of sleep do you get?____________

To the best of my knowledge the above information is complete and correct.
Patient Signature ______________________________ Date ________/________/_______
Staff Notes: ______________________________

Total Face-to-Face time:____________ Counseling Time:______________
Staff Signature: ______________________________Date ________/________/________

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