MALE - MEDICAL HEALTH HISTORY

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

Barron County DHHS - Public Health
335 E Monroe Ave, RM 338
Barron, WI 54812
715-537-5691 Fax: 715-537-6274

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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Date: _____/_____/_____

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:

Ovarian Cancer	___ Yes	___ No	Stroke	___ Yes	___ No	Diabetes	___ Yes	___ No
Breast Cancer	___ Yes	___ No	Heart Attack	___ Yes	___ No	High Cholesterol	___ Yes	___ No
Prostate Cancer	___ Yes	___ No	Blood Clot	___ Yes	___ No	High Blood Pressure	___ 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** _____/_____/_____