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. ☐ Heart attack/disease  5. ☐ High cholesterol  9. ☐ Mental illness

B. Personal Medical History:

1. Have YOU ever had problems with any of these? Check all that apply.
   A. ☐ Heart disease  J. ☐ Anemia  R. ☐ Liver problems or hepatitis
   B. ☐ High blood pressure  K. ☐ Sickle cell disease
   C. ☐ Stroke  L. ☐ Kidney/bladder problems  S. ☐ Gall bladder disease
   D. ☐ Diabetes  M. ☐ Seizures or epilepsy  T. ☐ Eating disorder
   E. ☐ High cholesterol  N. ☐ Depression  U. ☐ Cancer
   F. ☐ Tuberculosis (TB)  O. ☐ Suicidal thoughts  Type: _______________
   G. ☐ Asthma  P. ☐ Mental illness  V. ☐ Thyroid disease
   H. ☐ Blood clot in legs/lungs  Q. ☐ Severe headaches or migraines
   I. ☐ 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 rubella? ☐ I do not know

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

6. When was your last genial exam? ____________________________ ☐ I never had a genial exam

7. ☐ 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 pregnancy now? ☐ Very  ☐ Somewhat  ☐ Not at all

3. What birth control methods have you and your partner(s) used in the past? ☐ None
   A. ☐ Condoms/rubbers  F. ☐ IUD  J. ☐ Foam/film or jelly
   B. ☐ Birth control pills  G. ☐ Implants under the skin  K. ☐ Withdrawal/pulling out
   C. ☐ DepoProvera/shot  H. ☐ Diaphragm/cervical cap  L. ☐ Rhythm method
   D. ☐ Patch  I. ☐ Tubal ligation/tubes tied  M. ☐ Vasectomy
   E. ☐ NuvaRing (vaginal ring)

4. What birth control are you and your partner(s) 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  Have you ever used emergency contraception (morning after pill/Plan B)?

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?
### Habit and Lifestyle:

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
   - [ ] None

2. **Do you smoke cigarettes?**
   - [ ] Yes
   - [ ] No
   - [ ] Yes
   - [ ] No
   - [ ] None

3. **Do you use street drugs?**
   - [ ] Yes
   - [ ] No

4. **Have you ever used injected drugs?**
   - [ ] Yes
   - [ ] No

5. **Have you ever shared needles?**
   - [ ] Yes
   - [ ] No

6. **Has anyone ever told you that you have a problem with drugs or alcohol?**
   - [ ] Yes
   - [ ] No

7. **Is anyone, including your partner, threatening you, causing you to be afraid, or hurting you physically?**
   - [ ] Yes
   - [ ] No

8. **Have you ever been pressured or forced to have sex when you did not want to?**
   - [ ] Yes
   - [ ] No

9. **Have you ever had a sex partner with a history of:**
   - Injected drug use
   - HIV

### Sexual History:

In the last 12 months...

1. **Have you been sexually active?**
   - [ ] Yes
   - [ ] No
   - [ ] Not sure

2. **How many sexual partners have you had?**

3. **Have you had sex with:**
   - [ ] Men
   - [ ] Women
   - [ ] Both

4. **Has anyone, including your partner, threatening you, causing you to be afraid, or hurting you physically?**
   - [ ] Yes
   - [ ] No

5. **Have you traded sex for money or drugs?**
   - [ ] Yes
   - [ ] No

6. **Do you think that your partner(s) had other sexual partners?**
   - [ ] Yes, definitely
   - [ ] Not sure
   - [ ] No, very unlikely

7. **Is there anything else about your health or sexual practices that you would like to discuss with your clinician?**

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**Patient Signature/Date**

**Clinician Signature/Date**

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**Clinician Signature/Date Updated**

**Clinician Signature/Date Updated**