

**Health Quarters**  
Male Medical History

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I am adopted. ( )

Father - Living / Deceased    Mother - Living / Deceased (Please circle one)

PCP – Primary Care Physician: \_\_\_\_\_

Today's Date: \_\_\_\_\_

	NO	YES	COMMENTS
Are you <b>allergic</b> to any medication?			
Are you taking any <b>medication</b> now?			
<b>FAMILY HISTORY</b>			
Cancer (Please specify what type of cancer: _____)			
Diabetes			
Did your mother take DES while pregnant with you?			
<b>PERSONAL HISTORY    Have you ever had:</b>			
Kidney, Bladder, Urinary Tract Problems			
Liver Problems: Liver Disease, Hepatitis, Mononucleosis, Jaundice			
Cancer			
Blood transfusions, exposure to blood products or solid organ transplants			
Diabetes			
Fertility Problems or Disorders			
Other chronic <b>OR</b> acute medical conditions			
<b>STD HISTORY    Have you ever had: (Please circle all that apply)</b>			
Chlamydia    /    Gonorrhea    /    Syphilis    /    HIV			
Genital Herpes    /    Genital Warts    /    Chancroid    /    Hepatitis B			
NGU (Non-gonococcal urethritis)			
<b>LIFESTYLE    Have you ever:</b>			
Been forced to have sex or sexual contact when you didn't want to?			
Shared needles for injecting drugs (including steroids), tattooing, ear or body piercing - OR - had a partner that did?			
Used alcohol or other drugs before having sex?			
Do you smoke cigarettes? (How many per day? _____)			
Do you use alcohol / pot / crack / cocaine / heroin / tranquilizers / ecstasy?			
Have you had a Hepatitis B vaccination?			
Do you do testicular self-exams?			
<b>SEXUAL HISTORY</b>			
When was the last time you had sex? _____ -			
Do you use condoms? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never			
Do you have sex with <input type="checkbox"/> Women <input type="checkbox"/> Men <input type="checkbox"/> Both			
What kinds of sex do you have now OR have had in the past: <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Anal/Rectal			
In the last year, how many people have you had vaginal, oral or anal sex with? _____			
Do you have a partner who has multiple partners?                    No ( ) Yes ( ) Unknown ( )			
Do you have a partner who is at risk for STD/HIV?                    No ( ) Yes ( ) Unknown ( )			
Do you have a partner who is bisexual?                    No ( ) Yes ( ) Unknown ( )			

-----Staff Use Only-----

- STD info given
- HIV/ABC info given
- History reviewed
- Adolescents: Family involvement encouraged
- Abstinence encouraged