Central Montana Family Planning ~ 505 W. Main Street ~ Ste. 108 ~ Lewistown, MT 59457 ~ Phone & Fax: 406.535.8811

MALE PERSONAL HISTORY

Do you have or ever had the following: *(please check all that apply)*

A. REVIEW OF SYSTEMS

YES	NO	GENERAL
		1. My health is generally good
		2. Unexplained weight loss or gain of more than 10 lbs
		3. Cancer - If yes, where/when?
		4. Are you being treated for any illness / condition now? If yes, what ____________________

5. What medication are you currently taking? (please include over-the-counter, herbal or prescriptions)

YES	NO	EARS/NOSE/MOUTH/THROAT
		6. Hearing problems
YES	**NO**	**CARDIOVASCULAR**
		7. Heart murmur
		8. Blood clots (head/leg/lungs)
		9. Stroke or stroke-like problems
		10. High blood pressure
		11. High Cholesterol
YES	**NO**	**RESPIRATORY/UPPER BODY**
		12. Chronic cough or other breathing problem
		13. Asthma
		14. Tuberculosis or exposure to tuberculosis
		15. Breast lump or discharge
YES	**NO**	**GASTROINTESTINAL**
		16. Stomach or bowel problems
		17. Liver problems (hepatitis or tumor, etc.)
		18. Gallbladder problems
YES	**NO**	**GENITOURINARY**
		19. Bladder or kidney problems ❑Burning urination ❑Blood in urine
		20. Penis (discharge or pain)
		21. Genital sores, bumps or rashes
		22. Scrotal pain, swelling or abnormality
		23. Problems with erection or ejaculation
		24. History of hernia
		25. Pain with sex

26. Have you ever had any of the following? *(check all that apply)*

❑ Chlamydia	❑ Hepatitis (A, B, C)
❑ Gonorrhea	❑ Herpes
❑ Genital Warts (HPV)	❑ Syphilis
❑ HIV	❑ Trichomoniasis

YES	NO	MUSCULOSKELETAL
		27. Arthritis or osteoporosis
		28. Gout
YES	**NO**	**SKIN**
		29. Acne or other skin problems. Please Specify:
YES	**NO**	**PSYCHOLOGICAL**
		30. Depression
		31. Psychiatric illness
YES	**NO**	**ENDOCRINE**
		32. Thyroid problems
		33. Diabetes
YES	**NO**	**HEMATOLOGICAL / LYMPHATIC**
		34. Anemia
		35. Blood clotting disorder

YES	NO	ALLERGY / IMMUNOLOGY
		36. Are you allergic to any drug, medication, latex or other substance? What:
		37. MMR Immunization
		38. Hepatitis B Immunization (all 3 shots)

B. HOSPITALIZATION AND SURGERIES

Year	Reason

C. FAMILY HISTORY

YES	NO	
		39. Are you adopted?
		40. If you were born between 1940 and 1970, did your mother take DES to prevent a miscarriage?

41. Has your parent, sibling or grandparent had any of the following?

YES	NO	DIAGNOSIS	Relative
		Cancer (breast, colon, prostate, skin, testicular)	
		Diabetes	
		Genetic problems	
		Heart attack/stroke before age 50	
		High blood pressure	
		High blood cholesterol or fats	
		History of blood clotting disorders	
		Thyroid Problems	

D. OTHER SIGNIFICANT MEDICAL HISTORY

COMMENTS / EXPLANATIONS (by numbers): ***Staff Use Only***

Patient Name: ______________________ **Birthdate:** ____________ **Pt #** ____________

MALE PERSONAL HISTORY

E. PATERNITY HISTORY			COMMENTS / EXPLANATIONS (by numbers): *Staff Use Only*
42. How many children have you fathered? ____________			
43. Do you plan to have children? ❑Yes ❑No If yes, how soon? ❑Now ❑ 1-2 years ❑ 3-5 years ❑ 5+ years			
F. CONTRACEPTIVE HISTORY			
44. What birth control methods have you used? (check all that apply) ❑ condoms ❑ vasectomy ❑ withdrawal ❑ none ❑ other ___________________________________			
45. Does your partner use birth control? ❑ Yes ________________________________ ❑ No			
G. SOCIAL HISTORY			
YES	**NO**		
		46. Alcohol use: If yes, how many drinks? ___/day ___/week	
		47. Anorexia, Bulimia (binging, purging)	
		48. Tobacco use: If yes, ____cigs/day ____ cans/week	
		49. Physical abuse: ❑Past ❑Present	
		50. Sexual abuse: ❑Past ❑Present	
		51. Do you feel safe with your partner?	
		52. Would you like to discuss issues of abuse?	
I. SEXUAL HISTORY			
53. Age at first intercourse? _________________________________			
54. Have you ever had: ❑ oral sex ❑ anal sex ❑ vaginal sex			
55. How many sex partners have you had: ___ this year ___ life time?			
56. Have you had sex with: ❑ Men ❑ Women ❑ Both			
57. Has your partner had sex with: ❑Men ❑Women ❑Both ❑Unsure			
58. Has your partner had sex with someone other than you within the past year? ❑ Yes ❑ No ❑ I don't know			
YES	**NO**		
		59. Have you ever used needles to inject drugs?	
		60. If yes, have you shared needles or "works" Example: Injecting drugs, tattooing, piercing?	
		61. Have you received blood or blood products since 1978?	
		62. Have you ever had a partner who has had an STD?	
		63. Have you ever had a partner(s) who has used IV drugs?	
To the best of my knowledge the information I have provided is correct and complete.			
Patient Signature Date			
Staff Signature Date			

I have reviewed the above health history and have made notes in the margin to correct and update the information.

Date reviewed & updated: _____/_____/________ Patient signature: ____ Staff Initials: ___________

Date reviewed & updated: _____/_____/________ Patient signature: ____ Staff Initials: ___________

Date reviewed & updated: _____/_____/________ Patient signature: ____ Staff Initials: ___________

Patient Name: ____Birthdate:______________Pt #__________________