ALLEGANY COUNTY DEPARTMENT OF HEALTH REPRODUCTIVE HEALTH SERVICES
MALE HISTORY

NAME:_____DATE:_____ID#_____

MEDICAL HISTORY

Do you have OR have you ever had any of the following: (# amount if pertains)

	YES	NO		YES	NO		YES	NO
Seizure Disorder			Genital Warts			HIV Disease		
Stroke			Herpes			Hepatitis Disease		
HTN (hypertension)			Gonorrhea			Blood (Product)Transfusion		
Heart Disease			Chlamydia			Blood (Product) Exposure		
Rheumatic Fever			Syphilis			DES Exposure		
High Cholesterol						Drug Use (including injectables)		
Varicose Veins			Anemia			Alcohol Use		
Diabetes			Blood Clots			Tobacco Use (cig, chew,vape, eCig,cigar)		
Gallbladder Problems			Depression			Tattoos		
Liver Disease			Migraine Headaches			Body Piercing(s)		
Kidney Disease			Eye Problems					
Thyroid Disease			Skin Problems			**IMMUNIZATIONS:**		
Respiratory Disease			Physical Disability			Gardasil (HPV) Vaccine		
Breast Disease			Developmental Disability			Hepatitis B Vaccine		
Urological			Genetic Condition			Hepatitis A Vaccine		
Prostate						MMR Vaccine		
Cancer						Tdap Vaccine		
Varicocele						Varicella Vaccine		
						Influenza Vaccine		

SEXUAL & SOCIAL HISTORY:						
Do you use condoms?			Do you have children?			Age at 1st intercourse:
Do you use dental dams?			Do you want to have children? # yrs apart:_____			Total # of sexual partners in your lifetime:
Pain/burning upon urination?			Is your family supportive?			Who do you have sex with? □Men □Women □Both
History of sores on penis?			Who do you live with?			Type of sex you engage in? □Vaginal □Anal □Oral
Are sores painful?			Color of discharge:			Date of last intercourse:
History of discharge from penis? When:			Do you have any ALLERGIES? (if yes, list):			

DOMESTIC VIOLENCE SCREEN:
In the last year have you been hit, slapped, kicked, or physically hurt by a partner or significant other? □Yes □No
Have you ever been, or are you now, a victim of domestic violence or sexual abuse? □Yes □No
Are you in a relationship with someone who threatens or physically harms you? □Yes □No
Has anyone forced you to engage in sexual activities that made you feel uncomfortable? □Yes □No

I have completed the above information, which is true and accurate to the best of my knowledge. I also acknowledge that the information is provided for the sole purpose of assisting the staff to provide me with adequate care and that all information provided is strictly confidential and cannot be shared without written consent by myself.

CLIENT SIGNATURE:_____DATE:_____

STAFF SIGNATURE & TITLE:_____DATE:_____