

PLANNED PARENTHOOD OF INDIANA

Male History Form

Patient Name _____ PPIN # _____ Date _____

DOB _____ Age _____ B/P _____ Weight _____ Height _____

Reason for visit/current symptoms

Personal History (current or past)

- Yes___ no___ Migraine or severe headaches
- Yes___ no___ Hepatitis/liver disease
- Yes___ no___ Alcoholism/substance abuse
- Yes___ no___ Thyroid disease
- Yes___ no___ Emotional problems (depression/nerves)
- Yes___ no___ Hemorrhoids/rectal problems
- Yes___ no___ High blood pressure
- Yes___ no___ Asthma
- Yes___ no___ Mononucleosis
- Yes___ no___ Heart attack/stroke
- Yes___ no___ TB (tuberculosis)
- Yes___ no___ Kidney disease
- Yes___ no___ Painful urination/blood in urine
- Yes___ no___ Bladder/urinary tract infection
- Yes___ no___ Prostate problems
- Yes___ no___ Diabetes
- Yes___ no___ Cancer if yes, type _____
- Yes___ no___ Painful testicles
- Yes___ no___ Tumors/cysts/growths
- Yes___ no___ Discharge from penis
- Yes___ no___ Sickle cell disease/anemia
- Yes___ no___ Herpes
- Yes___ no___ Arthritis
- Yes___ no___ Genital warts
- Yes___ no___ Mumps Yes___ no___ orchitis/epididymitis
- Yes___ no___ Epilepsy/seizures
- Yes___ no___ German Measles (3 day)
- Yes___ no___ Trichomonas
- Yes___ no___ syphilis/gonorrhea/Chlamydia Yes___ no___ NGU
- Yes___ no___ genital lesions
- Yes___ no___ testicular masses
- Yes___ no___ hernias
- Yes___ no___ surgeries _____
- Yes___ no___ I drink _____ alcoholic beverages a week. Yes___ no___ I take antabuse.
- Yes___ no___ I would like to talk to someone about sexual concerns.
- Yes___ no___ My mother took DES (a drug to prevent miscarriage) when she was pregnant with me.
- Yes___ no___ I smoke _____ cigarettes a day.

Describe any serious illness or accident you have had in the last two years which required medicine or hospitalization: _____

Patient signature _____ Date _____

Staff signature _____ Date _____