

PLANNED PARENTHOOD OF INDIANA  
MALE MEDICAL HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ PPIN patient number \_\_\_\_\_

Reason for your visit today: \_\_\_\_\_

CONTRACEPTIVE HISTORY

YES \_\_\_ NO \_\_\_ Do you or your partner use any birth control now?

YES \_\_\_ NO \_\_\_ If yes, what method(s) do you use? \_\_\_\_\_ How long have you used this method? \_\_\_\_\_

YES \_\_\_ NO \_\_\_ Have you had problems with this or any birth control method? If yes, explain \_\_\_\_\_

SEXUAL HISTORY and HIV ASSESSMENT

Your answers to the following questions will help us assess your risk for sexually transmitted infections (STIs).

Age at first intercourse \_\_\_\_\_ How many lifetime partners have you had? \_\_\_\_\_ Current partners? \_\_\_\_\_

How frequently do you have intercourse? \_\_\_\_\_

YES NO

- Are you sexually active now? Check all that apply:  vaginal  anal  oral  other
- Have you had more than one, or a new, sexual partner in the past year? Are your partners male female both?
- Are you in a situation where you are being forced to have sex?
- Do you feel that any of your partners have put you at risk for sexually transmitted infections or HIV?
- Have you had a sexually transmitted disease such as gonorrhea, Chlamydia, syphilis, herpes or warts?
- Do you want to be tested for sexually transmitted infections or HIV?
- Do you have pain or bleeding with intercourse or other concerns about sex?
- Have you ever been tested for HIV?
- Do you know the results of your test?
- Do you use condoms when you have sex?
- Have you ever had sex while so drunk or high that you can't remember the details?
- Have you ever exchanged sex for drugs or money?
- Have you shared equipment to do body piercing or tattoos?
- Does your sex partner have sex with others?
- Has your sex partner been diagnosed with hepatitis, HIV, or other sexually transmitted diseases? If so, what? \_\_\_\_\_

What do you do now to protect yourself against HIV/AIDS? \_\_\_\_\_

What is your plan to decrease your risk for getting an STD or HIV/AIDS? \_\_\_\_\_

SOCIAL/ HEALTH RISK HISTORY

YES NO

- Do you smoke? How many cigarettes a day? \_\_\_\_\_
- Do you use alcohol? If yes, how often/how much? \_\_\_\_\_
- Do you use caffeine? What is your daily intake? \_\_\_\_\_
- Do you or your partners use street or IV (injectable) drugs?
- Do you or your partners share needles of any kind?
- Have you ever had or would you like help now with an alcohol or drug abuse problem?
- Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
- Are you now or have you ever been in a relationship where you have been physically hurt or threatened?
- Do you feel safe at home?
- Do you use seatbelts?
- Do you exercise? Activity \_\_\_\_\_
- Do you have concerns about your weight? Diet? Eating disorder?
- Are you exposed to work hazards at your place of employment?

Please list any ALLERGIES, including drug, metal, latex, skin allergies or irritants: \_\_\_\_\_

FAMILY HISTORY (If you are ADOPTED and DO NOT KNOW your biological family history, please skip this section.)  
Has anyone in your immediate family ever had the following? If yes, indicate father (F), mother (M), brother (B), or sister (S).

- \_\_\_\_ Death (age, cause of death) \_\_\_\_\_ Prostate cancer (age at onset \_\_\_\_\_)  
\_\_\_\_ Heart attack/ stroke (age at onset \_\_\_\_\_) \_\_\_\_\_ Other cancer  
\_\_\_\_ High blood cholesterol/ high blood pressure \_\_\_\_\_ Diabetes (insulin dependent?  Yes  No)  
\_\_\_\_ Huntington's disease \_\_\_\_\_ Seizures \_\_\_\_\_ Thyroid problems

Clients born **in the U.S. 1940-1970 or born overseas:** Did your mother take DES (hormones) during her pregnancy with you?  
 yes  no

PAST MEDICAL HISTORY

Have you ever had surgery or been a patient in a hospital?  yes  no If yes, describe \_\_\_\_\_

Do you have a disability?  yes  no If yes, explain \_\_\_\_\_

Are you now, or have you ever been, under a doctors' care for a serious illness or condition?  yes  no

If yes, describe \_\_\_\_\_

List any and all medications or drugs you are now taking or take often, including over-the-counter medications, herbal medications, and vitamins \_\_\_\_\_

Do you have another source of health care?  yes  no Do you have a source of dental care?  yes  no

REVIEW OF SYSTEMS Have you had or do you now have any of the following (please check each item)

1. General

YES NO

- my health is generally good  
  recent weight gain or loss  
  frequent colds, flu, etc  
  chronic fatigue >6 months  
  cancer \_\_\_\_\_  
  genetic condition  
  HIV/AIDS  
  transfusion blood/blood products

2. Immunizations

- rubella (German Measles)  
  Hepatitis A and B  
  DT

3. Cardiovascular

- heart disease/murmur  
  high blood cholesterol  
  varicose veins  
  high blood pressure  
  thrombophlebitis/blood clots in lungs  
or veins

4. Neurologic

- stroke  
  migraine (diagnosed by MD)  
  sensory difficulties (numbness, smell,  
taste, hearing)  
  seizures/ epilepsy

5. Gastrointestinal

YES NO

- stomach/ bowel problems  
  liver disease/jaundice/mono  
  hepatitis  
  gall bladder disease

6. Endocrine

- diabetes  
  thyroid problems

7. Respiratory

- asthma  
  TB  
  chronic cough

8. Genitourinary

- frequent bladder infections (>3/yr)  
  bladder, urinary or kidney problems  
  orchitis/epididymitis  
  testicular pain or masses  
  genital lesions  
  hernias  
  sexually transmitted disease:  
chlamydia, gonorrhea, herpes  
Syphilis, genital warts, other  
  breast problems: discharge, disease  
Tumor, surgery

9. Hematologic

YES NO

- anemia  
  blood clotting disorder  
  blood transfusion  
  sickle cell/Thallemia

10. Skin

- acne  
  chronic rash/ itching  
  other skin problems

11. Musculoskeletal

- arthritis  
  broken bones/ fractures

12. Eyes

- eye problems (not  
glasses/ contacts)

13. Ears, nose, throat, mouth

- frequent nosebleeds  
  hearing problems  
  teeth/gum problems  
  frequent sore throat

14. Psychology

- anxiety  
  depression  
  severe moodswings  
  under treatment

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Clinician signature \_\_\_\_\_ Date \_\_\_\_\_ Staff signature \_\_\_\_\_ Date \_\_\_\_\_

Annual review #1

- no change  change (see physical exam notes)

Clinician signature \_\_\_\_\_ Date \_\_\_\_\_ Staff signature \_\_\_\_\_ Date \_\_\_\_\_

Annual review #2

- no change  change (see physical exam notes)

Clinician signature \_\_\_\_\_ Date \_\_\_\_\_ Staff signature \_\_\_\_\_ Date \_\_\_\_\_