# Comprehensive Family Planning History - Male

Patient Identification:

Today's date: _____
Birth date: _____ Age: _____
List any medicines, foods, latex, etc. that you are allergic to and the reaction you have: _____

## Family History

| Yes | No | Have your grandparents, parents, or brothers/sisters had any of the following? If yes, please list who and at what age. |
|---|---|---|
| ☐ | ☐ | Blood clots in arms/legs/chest_____ |
| ☐ | ☐ | Bleeding problems _____ |
| ☐ | ☐ | High blood pressure_____ |
| ☐ | ☐ | High cholesterol/triglycerides_____ |
| ☐ | ☐ | Breast/ovarian/uterine/prostate/colon cancer _____ |
| ☐ | ☐ | Heart attack_____ |
| ☐ | ☐ | Stroke_____ |
| ☐ | ☐ | Diabetes_____ |
| ☐ | ☐ | Birth defects_____ |
| ☐ | ☐ | Alcohol/drug abuse _____ |

## Your Nutritional History

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Are there changes you would like to make to your diet? If yes, describe_____ |
| ☐ | ☐ | Are you on a special diet? (e.g. vegetarian, diabetic) If yes, please describe _____ |
| ☐ | ☐ | Do you exercise regularly? Describe_____ |

List other supplements, vitamins herbs or weight loss preparations you use:
_____

Is your weight: __ just about right __ too heavy ____too thin?

## Your Medical History

| Yes | No | Do you have now or have you had any of the following? |
|---|---|---|
| ☐ | ☐ | Are you taking any prescription or over the counter medicines now? Please list: _____ |
| ☐ | ☐ | Heart disease, high blood pressure |
| ☐ | ☐ | Blood clots in arms/legs/chest |
| ☐ | ☐ | Heart attack or stroke |
| ☐ | ☐ | High cholesterol/triglycerides |
| ☐ | ☐ | Cancer: What type? _____When?_____ |
| ☐ | ☐ | Blood problems (Sickle cell anemia, hemophilia, low iron) |
| ☐ | ☐ | Have you <u>or your partner</u> ever had a blood transfusion, tissue/organ transplant or artificial insemination? What year?_____ |
| ☐ | ☐ | Surgery - List type and date _____ |
| ☐ | ☐ | Liver disease (hepatitis, mono, jaundice, cirrhosis) |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Depression or emotional problems |
| ☐ | ☐ | If you were born before 1975, did your mother take DES when she was pregnant with you? |

## Immunization History (list dates(s))

| | | |
|---|---|---|
| ☐ | ☐ | Measles, mumps, rubella (MMR) vaccine_____ |
| ☐ | ☐ | Tetanus, diphtheria, pertussis (Td/Tdap) vaccine_____ |
| ☐ | ☐ | Hepatitis A vaccine_____ |
| ☐ | ☐ | Hepatitis B vaccine _____ |
| ☐ | ☐ | Varicella (chicken pox) vaccine_____ |
| ☐ | ☐ | HPV (human papilloma virus) vaccine_____ |
| ☐ | ☐ | Flu vaccine_____ |

Over

## Your Reproductive History

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Have you ever caused a pregnancy? If yes, how many children do you have? _____ |
| ☐ | ☐ | Do you plan a pregnancy in the future? |
| ☐ | ☐ | Are you using birth control?<br>Please check the birth control methods you use:<br>□ Condoms<br>□ Vasectomy □ Rely on partner's method. What method does your partner use?_____ |

## Your Urological History

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do you have abnormal discharge from the penis now? Describe _____ |
| ☐ | ☐ | Do you have now or in the past a lesion, sore, or lump on your penis?<br>Describe_____<br>When?_____ |
| ☐ | ☐ | Do you have now or in the past a lesion, sore, or lump on you scrotum or testicles?<br>Describe_____<br>When?_____ |
| ☐ | ☐ | Do you do Testicular Self Exam? |

Have you ever had any of the following infections?

☐ Chlamydia ☐ Gonorrhea
☐ Syphilis ☐ Herpes
☐ Genital warts/HPV ☐ Trichomoniasis

## Your Personal History

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do you smoke cigarettes? How many cigarettes a day?____ Smokeless tobacco?_____ |
| ☐ | ☐ | Do you drink alcohol? How many drinks a day?_____ week?_____ |
| ☐ | ☐ | Do you ever feel you should cut down on your drinking? |
| ☐ | ☐ | Are you using any street drugs? (Ecstasy, meth, weed, etc.) |
| ☐ | ☐ | Are you using prescription medication not prescribed for you? |
| ☐ | ☐ | Have you or your sexual partner(s) ever used needles for drugs? (shoot drugs) |
| ☐ | ☐ | Have you or your sexual partner(s) ever exchanged sex for drugs or money? |
| ☐ | ☐ | Do you use condoms?<br>Never____ Sometimes___ Always_____ |
| ☐ | ☐ | Have you had HIV testing? When? _____ |
| ☐ | ☐ | Are you HIV positive? |
| ☐ | ☐ | Have you ever been forced to have sex? |
| ☐ | ☐ | Have you ever been hit, slapped, kicked, shaken or hurt by anyone? |
| ☐ | ☐ | Is there anyone who makes you feel unsafe now? |
| ☐ | ☐ | Have you had a new partner in the last 2 months? |
| ☐ | ☐ | Does your sex partner have other partners? |

1. How many sexual partners have you had in the last 2 months?__
2. How many sexual partners have you had in the last year? _____
3. Are your sex partner's male _____ female _____ both _____?
4. Do you have oral sex_____ vaginal sex_____ anal sex_____?
5. When was the last time you had sex? _____

_____
Client signature

_____
Staff signature