Family Planning Program: Initial History and Examination – Male

Name:	**Date of Birth:**	**Date of Visit:**

The information you give us will be kept **confidential** and only disclosed to others with your written consent or as required by law.

FAMILY HISTORY

☐ I am adopted. (Please enter any information you have on your biological family; otherwise proceed to LIFE STYLE and MEDICAL HISTORY)

Information about blood relatives only (mother, father, siblings, grandparents)
Indicate if a member of your family has any of the following, (relationship and age of onset):

☐ Heart Disease/Stroke
☐ High Blood Pressure
☐ Cancer (breast, ovarian, colon, prostate, other)
☐ Diabetes
☐ Thyroid problems
☐ Other chronic conditions

If you were born between 1940 and 1970, did your mother take medication (DES) to keep from losing the pregnancy? ☐ NA ☐ Yes ☐ No ☐ Do not know

LIFE STYLE HISTORY

What concerns do you have about your weight?
☐ None ☐ Overweight
☐ Underweight ☐ Other: _____

What kind of tobacco do you use?
☐ None ☐ Smokeless: Daily _____ Weekly _____
☐ Cigarettes: #/day____ # yrs. _____

Have you had your immunizations (shots), especially
Rubella? ☐ Yes ☐ No ☐ Do not know
Hepatitis? ☐ Yes ☐ No ☐ Do not know

CONTRACEPTIVE HISTORY

What method of birth control have you used?
☐ Condoms ☐ Vasectomy ☐ None
Problems? ☐ No ☐ Yes _____
Have you ever caused a pregnancy?
☐ No ☐ Never tried ☐ Unsure
☐ Yes If yes: Number of times:_____

What method(s) of birth control are you using now?
☐ Condoms ☐ Vasectomy
☐ None ☐ Partner's
When did you last use this method? _____
Have you had sex without birth control or condoms in the last month? ☐ No ☐ Yes (dates)_____

What methods of birth control does your partner use?
(check all that apply)
☐ None ☐ Unsure ☐ Pills ☐ Shots (Depo)
☐ Patch ☐ Vaginal Ring ☐ IUD ☐ Implant
☐ Female Condom ☐ Vaginal spermicide

MEDICAL HISTORY (Yourself)

☐ Drug/medication Allergies (specify)
☐ Other Allergies (specify)

Which of the following do you take regularly: (please list)
☐ Prescriptions ☐ Over the Counter ☐ Street Drugs

Have you ever had surgery or been hospitalized?
☐ No ☐ Yes (Please list reasons)

☐ Headaches
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol or Triglycerides (Circle)
☐ Thyroid Disease
☐ Asthma
☐ Kidney Problems
☐ Hepatitis
☐ Other liver disease
☐ Diabetes
☐ Other chronic diseases?

UROLOGICAL HISTORY

Have you ever had any of the following? (Please √ all that apply)

☐ Abnormality of the penis (describe)
☐ Discharge from the penis (describe)
Are you having a problem with this now?
☐ Sores on the penis (describe)
Are you having a problem with these now?
☐ Sores or lumps on the scrotum? (describe)
Are you having a problem with these now?
Date first noticed:
Do you do Testicular Self Exam? ☐ No ☐ Yes

What Sexually Transmitted Diseases have you had?
(Please √ all that apply and give date of treatment)
☐ Chlamydia_____ ☐ Gonorrhea_____
☐ Herpes_____ ☐ Syphilis_____
☐ Trich _____ ☐ Warts _____
☐ Hepatitis (type ___) ☐ HIV_____
☐ Other (Please specify):_____
Treatment:_____

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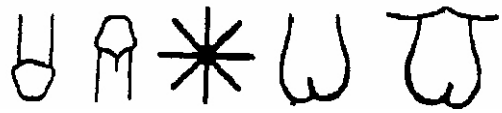
Name			**Date**
Height	**Weight**	**BMI**	**B/P**

Reason for Visit:

EXAM	WNL	Abnormal	NE
Skin			
Thyroid			
Cardiovascular			
Lungs			
Breasts			
Abdomen			
Extremities			
Penis			
Scrotum			
Anus			
Prostate			
Rectum			
Other			



Additional comments

☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Other

Assessment

Plan

Contraceptive Method:

☐ No Method (Indicate reason):

Medication:

☐ TSE Education

Referral: ☐ Lab Tests

RTC: ☐ Annual Exam: Mo._____ Yr._____ ☐ Supplies/PRN Prob.

Clinician's Signature: **Date:**