



PATIENT HISTORY FOR MALE HEALTH MAINTENANCE EXAM

Name: _____ Birthdate: ___/___/___ Today's date: ___/___/___

Please list all **Prescription Medications/Over-the-counter/Vitamins/Supplements** you are currently taking:

Table with 5 columns: Medication Name, Strength, Frequency, Reason for medication, Refill needed? (Y/N). Includes 10 rows for data entry.

List any **Medication Allergies** you may have:

Medication: _____ Reaction: _____

SOCIAL HISTORY

Education Level _____ Retired No Yes
Occupation: _____ Occupational hazards? _____
Marital Status: Married Single Divorced Widowed Life Partner Other: _____
Who lives in your home? Live Alone Spouse Children: _____ Father Mother Other: _____
Do you use Tobacco? Never Current user Former user Type: Cigarettes Chew Pipe Other: _____
Units/day: .5 1 1.5 2 Other: _____ Years used: _____ Years quit: _____
Do you drink Alcohol? No Yes Formerly How many drinks per week? 1-3 4-6 7-10 Other: _____
Do you drink Caffeine? No Yes Type of Caffeine: Soda Coffee Energy drinks Other: _____ Amount/day: _____

LIFESTYLE

Type of exercise: _____
Exercise Frequency: 2-3 times/week 3-4 times/week Daily Never Occasionally Hours/week: 0-5 5-10 10-15

Do you have a religious affiliation Y N Religion: _____ Is religion/spirituality an important part of your life? _Y N
Do you practice your religion? Y N Do you agree to transfusion? Y N

HOME ENVIRONMENT/SAFETY

Do you have smoke detectors in your home? Y N Pool/ spa at home? Y N
Do you have carbon monoxide detectors in your home? Y N Type of home heating? Gas Coal Electric Solar
Falls in the last year? Y N Number of falls: _____ Radon in the home? Y N
Firearms at home? Y N Number of firearms? _____ Locked storage? Y N
Do you use a seatbelt in the car? Always Never Occasionally
Do you have pets? What kind? _____

HEALTH MAINTENANCE

Date of last checkup: ___/___/___ Have you ever had a Colonoscopy? Y N Date: _____
Have you ever had a sexually transmitted disease? Y N If so, which one? _____
What are you doing to prevent getting HIV or a sexually transmitted disease? _____
Date of last prostate exam? ___/___/___ Have you had a PSA test? Y N Date: _____ Normal Abnormal
How many glasses of milk do you drink a day? 1 2 3 4 5 6
Enter the most recent dates of the following immunizations:
Tetanus _____ Pneumonia _____ Flu _____ Hepatitis B _____ Hepatitis A _____ MMR _____ Shingles _____

Continued on back side ->

PAST MEDICAL HISTORY

Please list all the Surgeries or Hospitalizations you have had:

Surgery or Reason for Hospitalization	Date	Hospital/City
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all current Medical Conditions or Illnesses for which you are being treated or followed by a physician:

Condition or Diagnosis	Date of Onset	Physician or Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any other significant Past Illnesses or Injuries from which you have completely recovered:

Injury/Illness/Diagnosis	Date
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

	Which Family Members?		Which Family Members?
Alzheimer’s Disease	Y N _____	High Cholesterol	Y N _____
Asthma	Y N _____	High Blood Pressure	Y N _____
Blood Disease	Y N _____	Mental Illness	Y N _____
Depression	Y N _____	Migraines	Y N _____
Cancer/Type	Y N _____	Osteoarthritis	Y N _____
CVA(stroke)	Y N _____	Osteoporosis	Y N _____
Diabetes	Y N _____	Heart Disease	Y N _____
		Other: _____	Y N _____

REVIEW OF SYSTEMS

Circle any item that relates to your current state of health: (Leaving an item unmarked indicates a NEGATIVE response)

GENERAL HEALTH

- Chills
- Fatigue
- Fever
- Malaise
- Night Sweats
- Weight Gain
- Weight Loss
- Other:**
- Exercise Intolerance
- Change in Appetite
- Irritability

HEENT

- Ear Drainage
- Ear Pain
- Eye Discharge
- Eye Pain
- Hearing Loss
- Nasal Drainage
- Sinus Pressure
- Sore Throat
- Visual Changes
- Other:**
- Difficulty Swallowing
- Double Vision
- Jaw Pain
- Mouth Ulcers
- Ringing in Ears
- Sensitivity to Light
- Snoring
- Tooth Pain

RESPIRATORY

- Chronic cough
- Cough
- Known TB exposure
- Shortness of breath
- Wheezing
- Other:**
- Apnea
- Asthma
- Coughing Blood
- Painful Respirations
- Respiratory Infections
- Trouble Breathing

CARDIOVASCULAR

- Chest Pain
- Leg Pain w/ Walking
- Edema
- Palpitations
- Other:**
- Irregular Heart Beat
- Loss of Consciousness
- Tingling in Extremity

GASTROINTESTINAL

- Abdominal Pain
- Blood in Stools
- Change in Stool
- Constipation
- Diarrhea
- Heartburn
- Loss of Appetite
- Nausea
- Vomiting
- Other:**
- Acid Reflux
- Fecal Incontinence
- Hemorrhoids
- Rectal Bleeding

GENITOURINARY

- Dribbling
- Painful Urination
- Blood in Urine
- Excessive Urination
- Slow Stream
- Urinary Frequency
- Urinary Incontinence
- Urinary Retention
- Other:**
- Flank Pain
- Foul Urine Odor
- Kidney Stones
- Recurrent UTI

REPRODUCTIVE

- Erectile Dysfunction
- Penile Discharge
- Sexual Dysfunction
- Other:**
- Circumcised
- Genital Lesions
- Blood in Semen
- Infertility
- Painful Ejaculation
- Testicular Mass
- Testicular Pain

METABOLIC/

- ENDOCRINE**
- Cold Intolerance
- Heat Intolerance
- Excessive Thirst
- Excessive Hunger
- Other:**
- Excessive Perspiration
- Growth Delay

NEUROLOGICAL

- Dizziness
- Extremity Numbness
- Extremity Weakness
- Gait Disturbance
- Headache
- Memory Loss
- Seizures
- Tremors
- Other:**
- Altered Mental Status
- Confusion/Disorientation
- Facial Droop
- Focal Weakness
- Frequent Falls
- Speech Changes
- Trouble Speaking

PSYCHIATRIC

- Anxiety
- Depression
- Insomnia
- Other:**
- Behavior Changes
- Difficulty Concentrating
- Difficulty Sleeping
- Excessive Stress
- Problems Coping
- Suicidal Thoughts

INTEGUMENTARY

- Brittle Hair
- Brittle Nails
- Hair Loss
- Hives
- Itching
- Mole Changes
- Rash
- Skin Lesion
- Other:**
- Acne
- Eczema
- Skin Infection

MUSCULOSKELETAL

- Back Pain
- Joint Pain
- Joint Swelling
- Muscle Weakness
- Neck Pain
- Other:**
- Arthritis
- Osteoporosis

HEMATOLOGIC/

- LYMPHATIC**
- Easy Bleeding
- Easy Bruising
- Swollen Lymph Nodes

IMMUNOLOGIC

- Contact Allergy
- Environmental Allergies
- Food Allergies
- Seasonal Allergies