Patient Centered Care, PLL-C
MALE HEALTH HISTORY

Name: _____ **Age:** _____ **Birth Date:** _____

Living Situation: Spouse _____ Alone _____ Partner _____ Friend(s) ____ Parents ____ Children ____ Other ____

What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific: _____
_____
_____

Please list any allergies you have to food or medications: _____
_____

Please list any medical problems that you are currently being treated for or have been treated for in the past: _____
_____
_____

Please list any surgeries that you have had including the date: _____
_____
_____

Please list any medications, prescription or *over-the-counter*, that you take: _____
_____

Do your parents have any of the following? (Mark all that apply - M = Mother, F=Father) Parents DOB: M F
___ Diabetes ___ Heart Attack ___ Cancer If so, what type? _____ ___ Stroke
___ High Cholesterol ___ High Blood Pressure ___ Blood clots ___ Heart disease/heart surgery

Do your grandparents have any of the following? (Mark all that apply – MGF =Maternal Grandfather, MGM = Maternal Grandmother, PGM=Paternal Grandmother, PGF= Paternal Grandfather)
___ Diabetes ___ Heart Attack ___ Cancer If so, what type? _____ ___ Stroke
___ High Cholesterol ___ High Blood Pressure ___ Blood clots ___ Heart disease/heart surgery

Do your sister/brothers have any of the following? (Mark all that apply – S= Sister, B= Brother)
___ Diabetes ___ Heart Attack ___ Cancer If so, what type? _____ ___ Stroke
___ High Cholesterol ___ High Blood Pressure ___ Blood clots ___ Heart disease/heart surgery

Date of last prostate exam? _____ PSA level drawn? ___ YES ___ NO Result: _____

Date of last sigmoidoscopy/colonoscopy: _____ Result: _____

Are you sexually active? ____ YES ____ NO With males, females, or both? _____

Have you ever had a testosterone blood level done? ___ YES ___ NO When? _____ Result: _____

Have you ever had an EKG, Stress Test, or Echocardiogram? ___ YES ___ NO When? _____ Result: _____

Do you get routine physical exercise? ___ YES ___ NO If yes, what type & how often? _____

Do you smoke cigarettes? ___ YES ___ NO If yes, # per day: _____ Age started: _____

Previous smoker? ___ YES ___ NO Age stopped: _____ Pack per day: _____ # of years: _____

Do you drink alcohol? ___ YES ___ NO If yes, how much per day? _____ What type? _____

Do you drink caffeine products? ___ YES ___ NO If yes, how much per day? _____ What type? _____