

Date: _____

Patient: _____

DOB: - -

Age: _____

Adult History Form - Male

Be sure to put your name on every page (top box)

Please list your primary concerns:

1. _____
2. _____
3. _____

How would you like to be Addressed?

Street Address:

MEDICATION ALLERGIES: (such as penicillin)
What happens when you take that medicine?

OTHER ALLERGIES: (such as bees/wasps, foods, latex, etc)
What happens when you are exposed:

MEDICATIONS: Prescription and Non-Prescription (including aspirin, vitamins, birth control, herbs, supplements, etc.)
Please include dose and when taken

PAST MEDICAL HISTORY

Please describe and give dates of any illnesses, injuries, hospitalizations, and surgeries:

IMMUNIZATIONS

Hepatitis B ___ Yes ___ No

Date:

Hepatitis A ___ Yes ___ No

Date:

Tetanus ___ Yes ___ No

Date:

Influenza (flu) ___ Yes ___ No

Date:

Have you had Chickenpox? ___ Yes ___ No

Date:

MMR (Measles, Mumps, Rubella) ___ Yes ___ No

Date:

“Pneumonia Shot” ___ Yes ___ No

Date:

Have you ever had a test for Tuberculosis? ___ Yes ___ No if yes (circle one) : Positive / Negative Date:

Have you ever had a blood transfusion? ___ Yes ___ No if yes: Dates:

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FAMILY HISTORY

Please check any family members who have the following health problems.

	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes						
Glaucoma						
Cancer (List type)						
Heart attack						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Mental Illness						
Suicide						
Other health problems						

SOCIAL HISTORY

Spouse's Name:	Spouse's Occupation:
Ages of Children:	# of People in Household:
Your Occupation:	Place Employed:
Level of Education:	Hobbies:

Recent Significant Changes in Your Life?	Yes	No	
Financial Hardships?	Yes	No	
Have Special Stresses in Your Life?	Yes	No	
I am NOT happy with (circle those that apply) →	Myself My Partner	My Health My Life	My Work
→ Because violence is so common in many people's lives, I've begun to ask all my patients about it.			
Have You Been In An Abusive Relationship?	___ Yes	___ No	
Does your partner ever hit you, hurt you, or threaten you in any way?	___ Yes	___ No	
Has your partner ever forced you to have sex when you didn't want to?	___ Yes	___ No	
Are you ever frightened of your partner?	___ Yes	___ No	
Has anyone ever hit you, hurt you, or threatened you in the past?	___ Yes	___ No	

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Tobacco Use:

Have you ever used **tobacco products** regularly? **Yes** **No** → if yes, please continue below:

Year Started	Circle those used	Amount	Year Quit	Still Use?
_____	Cigarettes	_____ pack/day	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Cigars	_____ #/week	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Smokeless/Chew	_____ Dips/day	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Pipe	_____ #/week	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you exposed to passive smoke? **Yes** **No**

Do you use other drugs or substances that could affect your health? **Yes** **No**

HIV/AIDS Risk:

Certain activities and medical problems can increase your risk for becoming infected with the HIV/AIDS virus. Please review the list of risks below:

- Have ever shared injection drug needles and syringes or "works."
- Have ever had sex without a condom with someone who had HIV/AIDS.
- Have ever had a sexually transmitted disease, like chlamydia or gonorrhea.
- Received a blood transfusion or a blood clotting factor between 1978 and 1985.
- Have ever had sex with someone who has done any of those things.

Do any of these activities or problems apply to you? **Yes** **No**

Caffeine Intake: On average, I drink caffeinated drinks this many times per day (circle) → 0 1 2 3 4 5+

Heart Disease Risk Factor:

Do you have a Family History of:

Heart Attack in a sister or mother before the age of 65 years of age? **Yes** **No**

Heart Attack in a brother or father before the age of 55 years of age? **Yes** **No**

Alcohol Use:

Check the **beverages** you regularly consume and list the amount you drink per DAY on average:

_____ Beer:	0	Less than 1	1	2	3	4	More than 4
_____ Wine:	0	Less than 1	1	2	3	4	More than 4
_____ Hard liquor:	0	Less than 1	1	2	3	4	More than 4
_____ Other:	0	Less than 1	1	2	3	4	More than 4

Drugs and Alcohol can sometimes effect your health and the medications you take. Please answer the following:

Yes	No	Have you ever felt you should cut down your drinking?
Yes	No	Have people annoyed you by criticizing your drinking?
Yes	No	Have you ever felt bad or guilty about your drinking?
Yes	No	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
Yes	No	In the last year, have you drunk or used non-prescription drugs to deal with your feelings, stress, or frustration?
Yes	No	As a result of your drinking or drug use, did anything happen in the last year that you wish didn't happen?

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ORGAN DONATION: Do you want to be an Organ Donor? ___ Yes ___ No ___ Don't Know

ADVANCED DIRECTIVES: Do you have an advanced directive or living will: ___ Yes ___ No

CURRENT HEALTH PRACTICES

Exercise, Safety, and Food can all play a role in your health.
Please answer the following questions to see what areas might put you at risk.

Do you exercise regularly? ___ Yes ___ No If Yes → Times per Week: _____

Type of exercise: _____

How often do you wear your seat belt?: ___ 100% of the time ___ 75% ___ 50% ___ 25% ___ Never

How often are you exposed to the sun? ___ Frequently ___ Occasionally ___ Rarely ___ A lot in the past

Please indicate the date of any of the following tests:

Colonoscopy (large intestine cancer screening test): ___ Never had one Date: _____

Digital Rectal Exam (prostate check): ___ Never had one Date: _____

PSA (Prostate Specific Antigen) – Cancer Screen: ___ Never had one Date: _____

How many meals do you eat per day? Snacks per day?

How many meals do you eat out per week?

Amount and type of **fluids** you consume per day:

List typical meals (Breakfast, Lunch, Dinner):

If you are on a **special diet**, please explain:

Are you happy with your weight? ___ Yes ___ No

Do you have regular **Dental** check-ups? ___ Yes ___ No How often do you brush/day _____ floss _____

___ Yes ___ No Do you ride a motorcycle?

___ Yes ___ No Bicycle?

___ Yes ___ No Ski/Snowboard?

___ Yes ___ No Skateboard?

If yes, do you wear a **helmet**? ___ Yes ___ No

Have you been exposed to any **Toxic Substances**, such as asbestos, DES, radiation, chemicals?

___ Yes ___ No → if yes, please explain:

Do you have a **smoke detector** in the home: ___ Yes ___ No When was it last checked?

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REVIEW OF SYSTEMS: Check the Yes or No column for those symptoms you currently have significant problems with.

Yes	No	General	Yes	No	Gastroenterology	Yes	No	Dermatology
		Fever			Nausea			Rash
		Chills			Vomiting			Itching
		Sweats			Diarrhea			Dryness
		Poor appetite			Constipation			Suspicious skin lesions
		Fatigue			Change in bowel habits			
		Weakness			Abdominal pain	Yes	No	Neurology
		Just don't feel well			Black or tar-like stools			Paralysis
		Weight loss			Bloody stools			Unusual sensations
		Sleep problems			Jaundice (skin turned yellow)			Seizures
					Gas/Bloating			Tremors
Yes	No	Eyes			Indigestion/Heartburn			Vertigo / Dizziness
		Blurring of your vision			Difficulty swallowing			Temporary blindness
		Double vision			Pain with swallowing			Frequent falls
		Irritation of the eyes						Frequent headaches
		Discharge of the eyes	Yes	No	Genitourinary			Difficulty walking
		Vision loss or change			Painful urination			
		Eye pain			Blood in the urine	Yes	No	Psychiatric
		Eyes are sensitive to light			Discharge from penis			Depression
					Frequent urination			Anxiety
Yes	No	Ears, Nose, Throat			Difficulty starting urine			Memory loss
		Earache			Frequent nighttime urination			Suicide thoughts
		Ear discharge			Incontinence / Leaking urine			Hallucinations
		Tinnitus / Ringing in Ears			Genital sores			Paranoia
		Decreased hearing			Decreased sex drive / libido			Phobia / Fear of things
		Nasal congestion			Problems keeping erection			Confusion
		Nose bleeds						
		Hoarseness				Yes	No	Endocrinology
			Yes	No	Musculoskeletal			Cold intolerance
Yes	No	Cardiovascular			Back pain			Heat intolerance
		Chest pains			Joint pain			Constantly thirsty
		Palpitations / Skipped beats			Joint swelling			Constantly hungry
		Syncope / Fainting			Muscle cramps			Constantly need to urinate
		Difficult breathing on exertion			Muscle weakness			Unusual weight change
		Difficult breathing laying down			Stiffness			
		Shortness of Breath at night			Arthritis	Yes	No	Hemetology
		Swelling in your legs or ankles			Sciatica / Pain down the legs			Unusual bruising
					Restless legs			Unusual bleeding
Yes	No	Respiratory			Leg pain at night			Enlarged lymph nodes
		Cough			Leg pain with exertion			
		Difficult breathing at rest				Yes	No	Allergy
		Excessive sputum / phlegm						Hives
		Coughing up blood						Allergic rash
		Wheezing						Hayfever
		Chest pain with deep breathing						Recurrent infections

