

MALE HISTORY & PHYSICAL

If you do not understand a question, please leave it blank

(All Information is Regarded as Confidential)

| | | | | | | | |
|-------------|-------|------------|-----|------|-------|------------|-----------------|
| Name (Last) | First | Birth Date | | | Date | Client No. | Master Record # |
| | | Month | Day | Year | _ _ _ | _ _ _ | _ _ _ |

ALLERGY HISTORY

Are you allergic to anything?
 (Medications, food, insects, environmental-grass, pollen) No

If yes, list allergy and reaction _____

MEDICATION HISTORY

Do you take any prescription or over-the-counter medications? No

If yes, list medications (include vitamins, herbs)

SERIOUS ILLNESSES OR HOSPITALIZATION

Have you ever had any serious illnesses or been hospitalized? No

If yes, please describe: _____

FAMILY HISTORY

Are you adopted? Yes No

Does anyone in your immediate **biological** family (parents, grandparents, brother/sister) have or ever had:

| | Yes | Relative |
|-------------------------------------|-----|----------|
| Diabetes..... | ___ | ___ |
| Cancer..... | ___ | ___ |
| High blood pressure..... | ___ | ___ |
| Heart attack before age 50..... | ___ | ___ |
| Blood disorders..... | ___ | ___ |
| Heart disease/high cholesterol..... | ___ | ___ |

GENERAL HISTORY

Do you now or have you ever had :

| Yes | No | Age |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes, sores, lesions anywhere on your body? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen glands in your groin _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach or bowel pain/problems _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had or been vaccinated against Hepatitis B (3 shots) _____ |

GENITAL HISTORY

Do you now or have you ever had:

| Yes | No | Age |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Pain, burning, difficult, frequent urination _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/bleeding with ejaculation/sex _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | A fever, or any flu-like symptoms _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sores on or around your penis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from penis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Urination or ejaculation in last 4 hours _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained or recent weight loss or hair loss _____ |

If you are uncomfortable with a question, you may leave it blank

STD HISTORY

Do you now or have you ever had:

| Yes | No | Mo/Yr |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Warts (Condylomata acuminata) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea (GC, Clap) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Trichomoniasis (Trich) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | NGU _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Syphilis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Yeast _____ |

Did you get treatment? Yes No
 Did you take all of your treatment medication? Yes No
 Has your partner(s) recently been diagnosed with an STD?
 If yes, was she/he treated? Yes No
 Does your partner have symptoms now?
 When was the last time you had sex with her/him? _____

SOCIAL / SEXUAL HISTORY

| Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you usually wear a seatbelt? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke cigarettes? Amount/day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol? Amount/week _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had sex? How many partners have you had in the last 60 days? _____ |
| | | Are your partners female <input type="checkbox"/> male <input type="checkbox"/> both <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your partner been with more than one partner? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been forced to have sex? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you engaged in risky behavior such as having sex while you or your partner are drunk or high on drugs; using drugs like Marijuana, LSD, Cocaine, Heroin, narcotics; having sex with many different partners; having sex for money, food, or shelter? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever use your mouth to have sex? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you ever use your rectum to have sex? |
| | | Do you use condoms always <input type="checkbox"/> sometimes <input type="checkbox"/> never <input type="checkbox"/> |

Client Signature _____

Date _____

Examiner's Comments: _____

Clinician Signature _____

Date _____

MALE PHYSICAL EXAMINATION (All Information is Regarded as Confidential)

Chief Complaint / Reason for Visit: _____

Date _____

BP _____ / _____ WT _____ HT _____

Initials

GENERAL

COMMENTS

| | WN L | ABN | |
|---------------|---------|-----|--|
| Thyroid | | | |
| Lungs | | | |
| Heart | | | |
| Breasts | | | |
| Abdomen/groin | | | |
| Extremities | | | |
| Hair Dist | | | |
| Skin | | | |

| | | |
|-----------------|---------|--|
| Genitalia | Ventral | |
| | | |
| Penis | | |
| | | |
| | | |
| Scrotum/Testes | Dorsal | |
| | | |
| | | |
| Rectum | | |
| | | |
| IMPRESSION: | | |
| | | |
| | | |
| TREATMENT PLAN: | | |
| | | |
| | | |

Patient Education

| | Yes | NA |
|-------------|--------------------------|--------------------------|
| Genetics | <input type="checkbox"/> | <input type="checkbox"/> |
| Safer Sex | <input type="checkbox"/> | <input type="checkbox"/> |
| STD | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoking | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Supplies Given/Comments: _____

Laboratory Tests

| Test | Result | Done Not Declined | | |
|------------------|--------|--------------------------|--------------------------|--------------------------|
| | | Done | Done | Declined |
| Urine | | | | |
| Protein _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glucose _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukocytes _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nitrites _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood | | | | |
| HGB _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | | | | |
| Seracult _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wet Mount _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chlamydia _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gonorrhea _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____ | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Notes: _____

Signature