

# TUSCOLA COUNTY HEALTH DEPARTMENT

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[www.tchd.us](http://www.tchd.us)

Date \_\_\_\_\_

## INITIAL MALE PATIENT HISTORY MEDICAL RECORD

ID# \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle

Maiden Name: \_\_\_\_\_

Marital Status:  Never Married  Married  Divorced  Widowed  Separated  Choose not to respond

Race (**Select one or more**):  White  Black  American Indian or Alaskan Native  
 Native Hawaiian or Pacific Islander  Asian  Other  Unknown

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Phone # \_\_\_\_\_

How may we contact you?  Phone  Letter

May we leave a message by phone?  Yes  No

If needed, provide another form of contact \_\_\_\_\_

If contacted by letter, can the envelope have the Health Department return address on it?  Yes  No

If you are under 18 years old, do your parents know you are here? \_\_\_\_\_

In case of emergency, who should we contact? \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

What is the last grade of school you completed \_\_\_\_\_ Grade in school now \_\_\_\_\_

Do you work?  Yes  No Full-time  Part-time  Where \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you enrolled in any other Health Department programs at this time or in the past?  Yes  No

How did you hear about our program? \_\_\_\_\_

Why are you here today? \_\_\_\_\_

**ALL INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR WRITTEN  
CONSENT, UNLESS REQUIRED BY LAW.**

**\* PLEASE GIVE YOUR CORRECT ADDRESS \***

**ALL CLIENTS UNDER THE AGE OF 18 ARE ENCOURAGED  
TO TALK WITH PARENTS ABOUT CONTRACEPTION**

**PERSONAL/SOCIAL HISTORY**

DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
Allergies (food, medications, latex)				
Do you use illegal drugs?				
Do you use alcohol? How much _____				
Do you use tobacco? Type _____ How much _____				

**SEXUAL HISTORY**

	YES	NO
Age of first sexual activity:		
Have you ever fathered a child?		
Have you ever had an STI?		
Do you do testicular self exam?		
Use of condoms: <input type="checkbox"/> Always <input type="checkbox"/> Occasionally <input type="checkbox"/> Never		
Last unprotected sex:		
How many partners have you had in the last year?		
What method of contraception used: <input type="checkbox"/> Vasectomy <input type="checkbox"/> Condom <input type="checkbox"/> Rely on Female Method <input type="checkbox"/> Abstinence <input type="checkbox"/> Other		

DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
Unusual penile discharge/burning with urination				
Chlamydia, gonorrhea, herpes, syphilis, HPV, etc.)				
Pain or bleeding with ejaculation				
Does your partner have any symptoms?				
Pain or discomfort in genitals (scrotum, groin, etc.)				

**PARTNER HISTORY**

Please check if your partner(s) has a history of any of these activities	YES	NO
Injectable drug use?		
Multiple partners?		
Bisexuality?		
History of STI's?		
History of HIV?		
Homosexuality		

**FAMILY HISTORY**

HAVE YOUR GRANDPARENTS, PARENTS, BROTHERS, OR SISTERS EVER HAD:	YES	NO	Relationship	STAFF NOTES ONLY
Early coronary artery disease (before age 50)				
High Blood Pressure				
Stroke				
Hyperlipidemia (elevated cholesterol)				
Diabetes				
Breast, colon, prostate, testicular cancer				
Osteoporosis				
If you were born between 1940-70, did your mother take DES (a hormone to prevent miscarriage)				
Genetic problems				

### PAST MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
Are you being treated for a chronic illness, such as high blood pressure, diabetes, cardiac disease, obesity, kidney or respiratory problems? If so, please list:				
Are you taking any over the counter or prescription medications? If so, please list:				
Have you had any surgeries? If so, please list:				
Have you ever been hospitalized? If so, for what and when:				
Have you had a blood transfusion before 1984?				

### REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
GENERAL HEALTH: (fatigue, weight gain/loss, fevers, recent illnesses)				
EYES: (visual problems, blurring)				
EARS/NOSE/THROAT: (hearing, sinus, oral lesions, difficulty swallowing)				
RESPIRATORY: (shortness of breath, cough, asthma, bronchitis, pneumonia, or bloody sputum)				
CARDIOVASCULAR: (high blood pressure, heart disease, murmurs, chest pains, elevated cholesterol)				
BLOOD DISORDERS: (anemia, blood clots, bleeding tendency, Sickle Cell Anemia, Factor V)				
GASTROINTESTINAL: (nausea/vomiting, ulcer, diarrhea/constipation, abdominal pain, hepatitis, mono, jaundice)				
URINARY: (urinary tract infection, kidney disease)				
MUSCULOSKELETAL: (arthritis, injuries, osteoporosis)				
ENDOCRINE: (thyroid disease, diabetes, appetite changes)				
SKIN/BREAST: (rash, change in mole, skin lesion, breast pain or mass/lump/thickness)				

DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
NEUROLOGICAL: (seizure disorder, stroke, severe pain/numbness in arms or legs, headaches)				
PSYCHIATRIC: (depressed/moody, anxiety, suicidal thoughts, plan or attempts)				
IMMUNIZATIONS: Up to date with: Measles/Mumps/Rubella Tetanus/Pertussis/Diphtheria Hepatitis B Series Flu				If not up to date, referred to Immunization Program <input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER PROBLEMS:				

ARE THERE ANY SPECIAL CONCERNS YOU HAVE TODAY? \_\_\_\_\_

To the best of my knowledge, the above information is complete and accurate and has been reviewed by the Family Planning staff.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date