Name **Age** **Date of Birth** **Date**

MALE MEDICAL HISTORY

This information is confidential and will be used by your medical provider to make sure you get proper care.

❑ Yes ❑ No Are you allergic to any medications? List here:

_____

❑ Yes ❑ No Do you take any over the counter medicines, prescription medicines, vitamins, supplements, or home remedies? List here:

_____

❑ Yes ❑ No Do you have a usual source of primary care? If yes, who?

_____

A. Family Medical History:

Has anyone in your family (mother, father, brother, sister) ever had:

1. ❑ Heart attack/disease
2. ❑ Stroke
3. ❑ Blood clot in legs/lungs
4. ❑ High blood pressure
5. ❑ High cholesterol
6. ❑ Diabetes
7. ❑ Alcohol or drug abuse
8. ❑ Birth defects/genetic problems
9. ❑ Mental illness
10. ❑ Maternal DES exposure
11. ❑ Cancer
12. ❑ I do not know my family medical history

B. Personal Medical History:

1. Have YOU ever had problems with any of these? Check all that apply.

A. ❑ Heart disease
B. ❑ High blood pressure
C. ❑ Stroke
D. ❑ Diabetes
E. ❑ High cholesterol
F. ❑ Tuberculosis (TB)
G. ❑ Asthma
H. ❑ Blood clot in legs/lungs
I. ❑ Bleed/bruise easily
J. ❑ Anemia
K. ❑ Sickle cell disease
L. ❑ Kidney/bladder problems
M. ❑ Seizures or epilepsy
N. ❑ Depression
O. ❑ Suicidal thoughts
P. ❑ Mental illness
Q. ❑ Severe headaches or migraines
R. ❑ Liver problems or hepatitis
S. ❑ Gall bladder disease
T. ❑ Eating disorder
U. ❑ Cancer Type:_____
V. ❑ Thyroid disease
W. ❑ Infertility

2. ❑ Yes ❑ No Have you ever been hospitalized or had any surgery?
   If yes, when and why? _____
3. ❑ Yes ❑ No Have you ever had a transfusion or blood exposure?
4. ❑ Yes ❑ No Have you been immunized against rubella? ❑ I do not know
5. ❑ Yes ❑ No Have you been immunized against hepatitis B? ❑ I do not know
6. When was your last genital exam? _____ ❑ I never had a genial exam
   ❑ Yes ❑ No Were you ever told there was any problem?
   If yes, what? _____
7. ❑ Yes ❑ No Have you ever had an HIV test?
   If yes, when was your last one? _____ Was it: ❑ Positive ❑ Negative?

C. Contraception History:

1. How old were you when you first had intercourse? ____ years old ❑ I never had sex
2. How important is it for you to avoid pregnancy now? ❑ Very ❑ Somewhat ❑ Not at all
3. What birth control methods have you and your partner(s) used in the past? ❑ None

A. ❑ Condoms/rubbers
B. ❑ Birth control pills
C. ❑ DepoProvera/shot
D. ❑ Patch
E. ❑ NuvaRing (vaginal ring)
F. ❑ IUD
G. ❑ Implants under the skin
H. ❑ Diaphragm/cervical cap
I. ❑ Tubal ligation/tubes tied
J. ❑ Foam/film or jelly
K. ❑ Withdrawal/pulling out
L. ❑ Rhythm method
M. ❑ Vasectomy

4. What birth control are you and your partner(s) currently using? _____ ❑ None
5. ❑ Yes ❑ No Are you happy with your method?
6. How often do you use condoms? ❑ Always ❑ Sometimes ❑ Never
7. ❑ Yes ❑ No Have you ever used emergency contraception (morning after pill/Plan B)?
8. ❑ Yes ❑ No Have you ever gotten anyone pregnant? ❑ Unsure
9. ❑ Yes ❑ No ❑ Maybe Are you and your partner planning to get pregnant in the next two years?

Provider notes:

Family PACT
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Name **Age** **Date of Birth** **Date**

D. Habit and Lifestyle:

If you prefer, you can talk to your health care provider about these important questions.

1. How many glasses of an alcoholic beverage do you have per week? _____ ❑ None
2. ❑ Yes ❑ No Do you smoke cigarettes? If yes, how many cigarettes per day? _____
3. ❑ Yes ❑ No Do you use street drugs? If yes, please list:_____
4. ❑ Yes ❑ No Have you ever used injected drugs?
5. ❑ Yes ❑ No Have you ever shared needles?
6. ❑ Yes ❑ No Has anyone ever told you that you have a problem with drugs or alcohol?
7. ❑ Yes ❑ No Is anyone, including your partner, threatening you, causing you to be afraid, or hurting you physically?
8. ❑ Yes ❑ No Have you ever been pressured or forced to have sex when you did not want to?
9. Have you ever had a sex partner with a history of: ❑ Injected drug use ❑ HIV

E. Sexual History:

In the last 12 months…

1. ❑ Yes ❑ No Have you been sexually active? If no, skip to #6.
   If yes, how many sexual partners have you had? _____
2. Have you had sex with: ❑ Men ❑ Women ❑ Both?
3. Have you and/or your partner(s) had: ❑ Oral sex ❑ Anal sex ❑ Vaginal sex?
4. ❑ Yes ❑ No Have you traded sex for money or drugs?
5. Do you think that your partner has other sexual partners?
   ❑ Yes, definitely ❑ Not sure, possibly ❑ No, very unlikely
6. In the last 12 months have you or your sex partner(s) had any of the following:
   A. ❑ Chlamydia D. ❑ Trichomoniasis (Trich) G. ❑ Syphilis
   B. ❑ Gonorrhea E. ❑ Pelvic Inflammatory Disease H. ❑ Other:_____
   C. ❑ Genital Herpes F. ❑ Genital warts
7. ❑ Yes ❑ No Is there anything else about your health or sexual practices that you would like to discuss with your clinician?

_____

_____

_____

_____

_____ _____
Patient Signature/Date Clinician Signature/Date

_____ _____
Clinician Signature/Date Updated Clinician Signature/Date Updated

Provider notes:

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