

MALE MEDICAL HISTORY QUESTIONNAIRE***PLEASE ANSWER ALL THAT IS APPLICABLE***

Date _____

Name _____ Age/ DOB _____

Primary Care Physician: _____

SURGICAL HISTORY: Please list any surgeries that you have had._____
_____**ALLERGIES:** Are you allergic to Latex? _____

List any medications you are allergic to: _____

Other allergies? (ex. Shellfish, Iodine, etc) _____

MEDICATIONS: Please list all medications or treatments you are currently taking: (Include any over-the counter or herbal medicines, vitamins, etc.)_____
_____**MEDICAL HISTORY:** List any / all medical problems (not surgeries) that you have seen a doctor for, take medicine for, or have ever been in the hospital for?_____
_____**FAMILY MEDICAL HISTORY:**

Do your parents, brothers, sisters or children have a history of any of the following (please circle):

Diabetes	Stroke	High blood pressure	Heart attacks	
Prostate Cancer	Colon Cancer	Blood clotting disorder	Bleeding disorders	Liver disease

Any other significant medical problems (not listed above) that have affected your family?

SOCIAL HISTORY:

How many children have you fathered? _____ What year(s) were your children born? _____

Do you plan on having more children? _____

Do you have a history of anabolic steroid use? _____

Any history of Opioid (prescription pain medication) use? _____

Do you smoke? _____

How often do you drink alcoholic beverages? _____ never _____ rarely _____ socially _____ most every day

Do you use any recreational/street drugs or any mood altering medications not prescribed to you? _____

Marital status: _____ married _____ single/never married _____ single/divorced _____ single/widowed

How many sexual partners have you had in the past year? _____