

PCHD Male Physical Evaluation History

Name: _____ Patient # _____ Date _____
Address: _____ Social Security # _____
City: _____ Date of Birth _____
State: _____ Zip code: _____ Telephone # _____
Marital Status: _____ Single _____ Married _____ Divorced _____ Separated
What is the best way to contact you? _____ Phone _____ Letter _____ You contact us unless emergency

Sexual History

Age at first sex: _____ Are you sexually active now? _____
Number of sex partners in last 6 months? _____ # of sex partners in your lifetime? _____
Type of sexual partners: _____ Male _____ Female _____ Both
Does your partner have partners who are: _____ Male _____ Female _____ Both
Type of sex practiced: _____ Vaginal _____ Oral _____ Anal

Contraceptive History

Are you, or your partner, using any contraceptive now? _____ Yes _____ No; What kind? _____
IN THE PAST, what methods of contraception have you used? (Circle all that apply)
Condoms _____ Withdrawal _____ Vasectomy _____
Spermicidal Foams _____ Natural/Rhythm _____ No method ever used _____
Do you have any biological children? _____ Yes _____ No If so, how many? _____
Have you been diagnosed with fertility problems? _____ Yes _____ No

Medical History

Do you have a family doctor? _____ Yes _____ No, if yes, Who? _____
Have you received medical care in the last year? _____ Yes _____ No
Do you have any chronic/ ongoing illnesses? _____ Yes _____ No, if yes, please explain: _____
Do you SMOKE cigarettes? _____ Yes _____ No, if yes, packs per day? _____
Do you DRINK alcohol? _____ Yes _____ No, if yes, what kind? BEER HARD LIQUOR WINE
Do you, or have you ever, used any street drugs? _____ Yes _____ No; What type? _____
Do you take any medications now (prescribed or over-the-counter)? _____ Yes _____ No, if yes,
What are the names of these medications? _____

Client's signature: _____ Date: _____

All of the information you have given us will be confidential. NO information will be released without your consent.

Staff
comments: _____

Staff reviewing information: _____ Date: _____

Client name: _____

Client # _____

MALE MEDICAL HISTORY

DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

CONDITION	YES	NO	UNSURE	STAFF COMMENTS
Unusual penile discharge				
Urinary burning/pain				
Urologic conditions				
Gonorrhea				
Chlamydia				
Herpes				
Genital warts (HPV)				
Trichomoniasis				
Syphilis				
Hepatitis B or vaccine				
Hepatitis C				
HIV/AIDS				
Bladder pain				
Testicular pain				
Testicular lump or mass				
Pain or bleeding with sex				
Blood in semen				
Severe headaches				
Vision headaches				
Glasses or contacts				
Thyroid disease				
Heart problems/murmur				
Chest pain/ Difficulty breathing				
Respiratory problems/ Asthma				
High blood pressure				
High cholesterol				
Stomach problems				
Diabetes				
Cancer				
Birth defects				
Sickle cell anemia				
Obesity				
Hospitalizations/ Surgery				
Immunizations current				
Other medical problems				
Allergies to medication				
Allergies to other things				

The history provided is complete and accurate to the best of my knowledge.

Client's signature _____

Date _____