Patient Name_____ DOB_____

## Male Patient Health History

***All answers are confidential (17 & above self-administered)***

Are you allergic to any drugs or food?_____

***Sexual History:***

Have you ever had sex?_____

How old were you when you first had sex?_____

How old is your partner?_____

Do you have sex with (circle one) Males Females Both

Do you use condoms?_____

Do you use dental dams (for oral sex)?_____

When was the last time you had sex?_____ Did you use a condom?_____

Do you have any children?_____ If so, how many?_____

***Please turn over and complete back of the questionnaire. Thank you.***

***Patient Medical/Surgical/Dental History. Please check Yes or No.***
***Have you ever had any of the following?***

| Frequent headaches | **Yes** | **No** | Surgery/Biopsy | **Yes** | **No** |
|---|---|---|---|---|---|
| Eye problems (glasses/contacts) | | | Overnight stay in the hospital | | |
| Ear problems | | | Blood transfusion | | |
| Seizures/epilepsy | | | Immunizations/vaccines | | |
| Thyroid problems | | | HPV Vaccine | | |
| Heart problems | | | Sexually transmitted infections | | |
| High blood pressure | | | Blood clots (legs/lungs/arms) | | |
| Blood disorders (anemia) | | | Skin problems (eczema) | | |
| Breast problems (lumps, cysts) | | | High cholesterol | | |
| Asthma/breathing problems | | | cancer | | |
| Digestive problems/ulcers | | | Depression/anxiety/suicide attempts/mental health problems | | |
| Bladder/urinary/kidney problems | | | Smoke cigarettes | | |
| Hepatitis/liver/gallbladder problems | | | Drugs (marijuana, cocaine, pills, etc.) | | |
| Diabetes/gestational diabetes | | | Drink alcohol (beer, wine, liquor) | | |
| Bone/back problems or pain | | | Other medical problems not listed | | |
| Chronic illness | | | Exposure to lead/environmental risk | | |
| Injuries/accidents/broken bones | | | Tuberculosis/positive TB test | | |
| Occupational hazards: at work are you exposed to any of the following:<br>Blood Bodily Fluids Asbestos Chemicals Fumes Needles/Sharps | | | | | |

***Does anyone in your immediate family have any of the following? (mother, father, sister, brother, grandparents)***

| High blood pressure | **Yes** | **No** | High cholesterol | **Yes** | **No** |
|---|---|---|---|---|---|
| Heart problems | | | Tuberculosis | | |
| Stroke | | | Cancer | | |
| Diabetes | | | Genetic problems | | |
| Blood Clots | | | Mental Health Problems | | |
| Other health problems: | | | | | |

***Dental History:***

| Do you drink tap water or take any fluoride supplements? | **Yes** | **No** |
|---|---|---|
| Have you ever had any complications from having dental work done? | | |
| Have you ever had any reactions to medications or anesthesia provided by a dentist? | | |
| Have you had any dental surgeries/biopsies/procedures? | | |
| How many times a day do you brush your teeth? | | |
| How many times a day do you floss? | | |
| How often do you see a dentist? | | |
| When was the last time you saw a dentist? | | |