

# ADULT HISTORY: MALE

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## PAST MEDICAL HISTORY: (PMH)

- |   |  |
|---|--|
| <input type="checkbox"/> Unremarkable               | <input type="checkbox"/> Gout                                |
| <input type="checkbox"/> Alzheimer's Disease        | <input type="checkbox"/> Hepatitis A                         |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Hepatitis B                         |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Hepatitis C                         |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Hyperlipidemia                      |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Hypertension                        |
| <input type="checkbox"/> Atrial Fibrillation        | <input type="checkbox"/> Hyperthyroidism                     |
| <input type="checkbox"/> Autoimmune Disorder        | <input type="checkbox"/> Hypothyroidism                      |
| <input type="checkbox"/> Blood Transfusions         | <input type="checkbox"/> Incontinence                        |
| <input type="checkbox"/> Brain Tumor                | <input type="checkbox"/> Infertility                         |
| <input type="checkbox"/> Cataract                   | <input type="checkbox"/> Inflammatory Bowel Disease          |
| <input type="checkbox"/> Cancer - Breast            | <input type="checkbox"/> Kidney Disease                      |
| <input type="checkbox"/> Cancer - Colon             | <input type="checkbox"/> Kidney Stone                        |
| <input type="checkbox"/> Cancer - Lung              | <input type="checkbox"/> Liver Disease                       |
| <input type="checkbox"/> Cancer - Prostate          | <input type="checkbox"/> Lupus                               |
| <input type="checkbox"/> Cancer - Skin              | <input type="checkbox"/> Macular Degeneration                |
| <input type="checkbox"/> Cancer - Thyroid           | <input type="checkbox"/> Migraine Headache                   |
| <input type="checkbox"/> Chrohn's Disease           | <input type="checkbox"/> Multiple Sclerosis                  |
| <input type="checkbox"/> Chronic Low Back Pain      | <input type="checkbox"/> MI (Heart Attack)                   |
| <input type="checkbox"/> Cirrhosis                  | <input type="checkbox"/> Osteoarthritis                      |
| <input type="checkbox"/> Congestive Heart Failure   | <input type="checkbox"/> Osteopenia                          |
| <input type="checkbox"/> Constipation, Chronic      | <input type="checkbox"/> Osteoporosis                        |
| <input type="checkbox"/> COPD                       | <input type="checkbox"/> Parkinson's Disease                 |
| <input type="checkbox"/> Coronary Artery Disease    | <input type="checkbox"/> Peptic Ulcer Disease                |
| <input type="checkbox"/> CVA/Stroke                 | <input type="checkbox"/> Polymyalgia Rheumatica              |
| <input type="checkbox"/> Degenerative Joint Disease | <input type="checkbox"/> Psoriasis                           |
| <input type="checkbox"/> Dementia                   | <input type="checkbox"/> Polymyalgia Rheumatica              |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Rheumatoid Arthritis                |
| <input type="checkbox"/> Diabetes Type 1            | <input type="checkbox"/> Seizure Disorder                    |
| <input type="checkbox"/> Diabetes Type 2            | <input type="checkbox"/> Tuberculosis                        |
| <input type="checkbox"/> Diverticulitis             | <input type="checkbox"/> Urinary Tract Infections, Recurrent |
| <input type="checkbox"/> DVT (Clot)                 | <input type="checkbox"/> Varicose Veins                      |
| <input type="checkbox"/> Eczema                     |  |
| <input type="checkbox"/> Fibromyalgia               |  |
| <input type="checkbox"/> GERD (gastric reflux)      |  |
| <input type="checkbox"/> Glaucoma                   |  |
| <input type="checkbox"/> GI Bleed                   |  |

Other: \_\_\_\_\_

# ADULT HISTORY: MALE

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**PAST SURGICAL HISTORY: (PSH)**

	<u>DATE</u>		<u>DATE</u>
<input type="checkbox"/> Unremarkable	_____	<input type="checkbox"/> Gastric Bypass	_____
<input type="checkbox"/> Abdominal Aortic Aneurysm Repair	_____	<input type="checkbox"/> Hemorrhoidectomy	_____
<input type="checkbox"/> Abdominal Surgery	_____	<input type="checkbox"/> Hernia – Incisional	_____
<input type="checkbox"/> Amputation	_____	<input type="checkbox"/> Hernia – Inguinal	_____
<input type="checkbox"/> Anesthesia Problem – No	_____	<input type="checkbox"/> Hernia – Umbilical	_____
<input type="checkbox"/> Anesthesia Problem - Yes	_____	<input type="checkbox"/> Hernia – Ventral	_____
<input type="checkbox"/> Aortic Valve Replacement	_____	<input type="checkbox"/> Laminectomy	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Lap Band Procedure	_____
<input type="checkbox"/> Aorto-Femoral Bypass	_____	<input type="checkbox"/> Mitral Valve Replacement	_____
<input type="checkbox"/> Arthroplasty – Total Hip Replacement	_____	<input type="checkbox"/> Kidney Transplant	_____
<input type="checkbox"/> Arthroplasty–Total Knee Replacement	_____	<input type="checkbox"/> Pacemaker	_____
<input type="checkbox"/> Arthroscopy – Scoping of Knee	_____	<input type="checkbox"/> Pacemaker with ICD Placement	_____
<input type="checkbox"/> Back Surgery	_____	<input type="checkbox"/> Parathyroidectomy (Parathyroid Removed)	_____
<input type="checkbox"/> Breast Biopsy	_____	<input type="checkbox"/> Pneumonectomy (Lung Removed)	_____
<input type="checkbox"/> Breast Surgery	_____	<input type="checkbox"/> Prostatectomy (Prostate Removed)	_____
<input type="checkbox"/> Bronchoscopy (Scoping of Lungs)	_____	<input type="checkbox"/> PTCA (Heart Stent)	_____
<input type="checkbox"/> CABG – Coronary bypass surgery	_____	<input type="checkbox"/> Rotator Cuff Repair	_____
<input type="checkbox"/> Carotid Endarterectomy	_____	<input type="checkbox"/> Sinus Surgery	_____
<input type="checkbox"/> Carpal Tunnel	_____	<input type="checkbox"/> Surgical Complication	_____
<input type="checkbox"/> Cataract(s) Removed	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Cholecystectomy (Gallbladder Removed)	_____	<input type="checkbox"/> TURP	_____
<input type="checkbox"/> Cholecystectomy (Gallbladder Removed)	_____	<input type="checkbox"/> Urinary Incontinence Surgery	_____
<input type="checkbox"/> Circumcision	_____	<input type="checkbox"/> Vascular Surgery	_____
<input type="checkbox"/> Colon Resection	_____	<input type="checkbox"/> Vasectomy	_____
<input type="checkbox"/> Colostomy	_____	<input type="checkbox"/> Vein Stripping	_____
<input type="checkbox"/> Craniotomy	_____		

Other: \_\_\_\_\_

**Medications and How You Take Them (Include vitamins and herbals):**

Name: _____	Strength: _____	Amount/day: _____
Name: _____	Strength: _____	Amount/day: _____
Name: _____	Strength: _____	Amount/day: _____
Name: _____	Strength: _____	Amount/day: _____
Name: _____	Strength: _____	Amount/day: _____
Name: _____	Strength: _____	Amount/day: _____
Name: _____	Strength: _____	Amount/day: _____

Allergies: Y N If yes, please list: \_\_\_\_\_

# ADULT HISTORY: MALE

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## FAMILY HISTORY: (FH)

- |   |  |
|---|--|
| <input type="checkbox"/> FH Unknown                             | <input type="checkbox"/> FH Growth/Development                     |
| <input type="checkbox"/> FH Alcoholism                          | <input type="checkbox"/> FH Headaches                              |
| <input type="checkbox"/> FH Anemia                              | <input type="checkbox"/> FH Heart Disease                          |
| <input type="checkbox"/> FH Anesthetic Complications            | <input type="checkbox"/> FH Hypertension                           |
| <input type="checkbox"/> FH Angina                              | <input type="checkbox"/> FH High Cholesterol                       |
| <input type="checkbox"/> FH Anxiety                             | <input type="checkbox"/> FH Kidney Disease                         |
| <input type="checkbox"/> FH Arthritis                           | <input type="checkbox"/> FH Lung Cancer                            |
| <input type="checkbox"/> FH Asthma                              | <input type="checkbox"/> FH Lung/Respiratory                       |
| <input type="checkbox"/> FH Birth Defects                       | <input type="checkbox"/> FH Melanoma                               |
| <input type="checkbox"/> FH Bleeding Disease                    | <input type="checkbox"/> FH Migraines                              |
| <input type="checkbox"/> FH Breast Cancer                       | <input type="checkbox"/> FH Osteoporosis                           |
| <input type="checkbox"/> FH Coronary Heart Disease – Male <55   | <input type="checkbox"/> FH Other Cancer (Specify Below)           |
| <input type="checkbox"/> FH Coronary Heart Disease – Female <65 | <input type="checkbox"/> FH Ovarian Cancer                         |
| <input type="checkbox"/> FH Cervical Cancer                     | <input type="checkbox"/> FH Premenstrual Syndrome (PMS)            |
| <input type="checkbox"/> FH Colon Cancer – Father               | <input type="checkbox"/> FH Psychiatric Care                       |
| <input type="checkbox"/> FH Colon Cancer – Mother               | <input type="checkbox"/> FH Seizures                               |
| <input type="checkbox"/> FH Colon Cancer                        | <input type="checkbox"/> FH Severe Allergies                       |
| <input type="checkbox"/> FH Depression                          | <input type="checkbox"/> FH Stroke                                 |
| <input type="checkbox"/> FH Diabetes                            | <input type="checkbox"/> FH Thyroid Problems                       |
| <input type="checkbox"/> FH Endometriosis                       | <input type="checkbox"/> FH Uterine Cancer                         |
|   | <input type="checkbox"/> FH Weight Disorder                        |
|   | <input type="checkbox"/> FH Other Medical Problems (Specify Below) |

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SOCIAL HISTORY: (SH)

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Married     | <input type="checkbox"/> History of Domestic Abuse |
| <input type="checkbox"/> Divorced    | <input type="checkbox"/> Religion Affecting Care   |
| <input type="checkbox"/> Separated   | <input type="checkbox"/> Passive Smoke Exposure    |
| <input type="checkbox"/> Single      | <input type="checkbox"/> Military Service          |
| <input type="checkbox"/> Widowed     | <input type="checkbox"/> Service Disability        |
| <input type="checkbox"/> 1 Child     | <input type="checkbox"/> Other Disability          |
| <input type="checkbox"/> 2 Children  |  |
| <input type="checkbox"/> 3 Children  |  |
| <input type="checkbox"/> 4+ Children |  |

ADULT HISTORY: MALE

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

RISK FACTORS: Please answer the following questions in order to better assess your health risk factors.

Tobacco Use:

Currently Smoking:

- Cigarettes                      Amt: \_\_\_\_\_ packs/day
- Cigars                                Amt: \_\_\_\_\_ # per week
- Smokeless/chewing            Amt: \_\_\_\_\_ per day

Previous Smoker:

Year Started: \_\_\_\_\_  
 Year Quit: \_\_\_\_\_  
 Pack-Years: \_\_\_\_\_  
 Comments: \_\_\_\_\_

Never Smoked

Passive Smoke Exposure (Second Hand Smoke):  Yes  No

Drug Use:  None

If Yes: Substance Type:  Marijuana  Cocaine  Crack  Heroin  Illegal Prescription Drugs  
 Other: \_\_\_\_\_  
 Comments: \_\_\_\_\_

HIV High Risk Behavior:  Yes  No

Alcohol Use:  Yes  No

Drinks per Day:  <1  1  2  3  4  4+

If Yes: Type \_\_\_\_\_

Caffeine Use: Drinks per Day:  0  1  2  3  4  5+

Exercise: Times per Week  1  2  3  4  5  6  7  8+

Seat Belt Use:                      Percentage of Time Used:  100  75  50  25  0

Sun Exposure:                       Frequently  Occasionally  Rarely