



For Male Patients Age 13 and Up

Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):

DOB:

Previous or referring doctor:

Date of last physical exam:

TYPES OF PERFORMANCE



PHYSICAL HEALTH

Do you exercise?

- No
- Mild exercise (i.e. climb stairs, walk 3 blocks, bike riding)
- Occasional vigorous exercise (i.e. sports or recreation, less than 4x/week for 30 minutes)
- Regular vigorous exercise (i.e. sports or recreation 4x/week for 30 minutes)

What kinds of exercise do you enjoy?

What do you like most about exercise?

What do you like least about exercise?

Physical accomplishments that you are proud of:



**ACADEMIC /
DEVELOPMENTAL HEALTH**

Where do you go to school?

What do you like most about school?

Do you have a favorite class?

What do like least about school?

Are you struggling with any particular class?

Academic achievements that you are proud of:



**CREATIVE EXPRESSION /
EMOTIONAL HEALTH**

Do you have a creative outlet (music, art, drama, writing, etc.)? This includes things like listening to music, reading a book for pleasure or visiting with friends. Things like Yoga or Dance Class would be both physical and creative expression (it's okay to have items in more than one category).

How often do you participate in a creative activity?

Do you feel like you have good stress management skills?

What creative accomplishments are you proud of:

PERSONAL HEALTH HISTORY

Immunizations and dates:

<input type="checkbox"/> DTAP		<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Hep A		<input type="checkbox"/> Chickenpox	
<input type="checkbox"/> Hep B		<input type="checkbox"/> Meningitis	
<input type="checkbox"/> Influenza		<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?

Yes No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications							
Name the Drug		Reaction You Had					
HEALTH HABITS AND PERSONAL SAFETY							
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.							
Diet	Are you dieting?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	# of meals you eat in an average day?						
Alcohol	Do you drink alcohol?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, what kind?						
	How many drinks per week?						
	Are you concerned about the amount you drink?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Have you considered stopping?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Have you ever experienced blackouts?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Are you prone to "binge" drinking?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Do you drive after drinking?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tobacco	Do you use tobacco?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day		<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit					
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Sex	Have you ever had sex? With men, women or both? (circle one)			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, any discomfort with intercourse?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	If yes, what type of birth control is being used?						
	Have you ever had an STD?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
	Have you ever gotten anyone pregnant?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Family Life	Physical and/or mental abuses have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Grandmother		
Mother			Maternal		
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather		
	<input type="checkbox"/> M <input type="checkbox"/> F		Maternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother		
	<input type="checkbox"/> M <input type="checkbox"/> F		Paternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather		
	<input type="checkbox"/> M <input type="checkbox"/> F		Paternal		
	<input type="checkbox"/> M <input type="checkbox"/> F		Other:		
	<input type="checkbox"/> M <input type="checkbox"/> F				

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney or bladder infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

