Women's Wellness Center

Male Medical History Form

Name _____ **Date of Birth** _____ **Today's date** _____

Drug Allergies: _____

Are You Allergic to LATEX? ( ) Yes ( ) No

Your Personal Health History. Check all that apply:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke
- ☐ Heart Attack
- ☐ Arthritis
- ☐ Hemochromatosis
- ☐ Depression/Anxiety
- ☐ Psychiatric Disorder
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer of Testicle or Prostate (Year _____)
- ☐ Other Cancer (and Year) _____
- ☐ Trouble passing urine or take Flomax or Avodart
- ☐ Chronic Liver Disease
- ☐ Prostate Enlargement
- ☐ Elevated PSA
- ☐ Blood Clot or Pulmonary Embolus

Other Medical Conditions: _____

Current Medications and Dosage:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Nutritional/Vitamin Supplements:

_____ _____ _____
_____ _____ _____

Past Surgeries (list year):

_____
_____

Do you smoke/vape? ( ) No ( ) Quit ( ) Yes # Cigs per day? _____ Age started ____

Do you drink alcohol? ( ) No ( ) Quit ( ) Yes # Drinks per day/week _____ Age started ____

Do you have a FAMILY History of:

- ☐ Heart Disease -- Which relatives? _____
- ☐ Diabetes -- Which relatives? _____
- ☐ Cancer -- What cancer? Which relatives? _____

Other pertinent information:

_____
_____

Patient Signature _____