Columbia Pelvic & Hormone Health

Male Medical History Form

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

DRUG ALLERGIES: _____

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

PERSONAL HEALTH HISTORY: Check all that apply:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Blood Clot or Embolus
- ☐ Liver Disease
- ☐ Hemochromatosis
- ☐ Diabetes
- ☐ Arthritis
- ☐ Anxiety
- ☐ Depression
- ☐ Thyroid Disease
- ☐ Obstructive Sleep Apnea
- ☐ Trouble Passing Urine
- ☐ Prostate Enlargement
- ☐ Elevated PSA (Blood Test)
- ☐ Prostate Cancer
- ☐ Testicular Cancer
- ☐ Breast Cancer

Ever tested positive for COVID? ( ) Yes ( ) No **How many COVID vaccinations have you received?** _____

Other Medical Conditions:

_____

_____

PAST SURGERY (list year):

_____

_____

CURRENT MEDICATIONS AND DOSAGE:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Have you been prescribed a Medical Marijuana Card? ( ) No ( ) Yes - If Yes, for what condition? _____

SOCIAL HISTORY:

Marital Status: ( ) Single ( ) Live with partner ( ) Married ( ) Separated ( ) Divorced

Employer: _____ **Occupation:** _____

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

Do you drink alcohol? ( ) No ( ) Quit ( ) Yes # Drinks per day? _____

FAMILY MEDICAL HISTORY:

- ☐ Heart Disease -- Which relatives? _____
- ☐ Diabetes -- Which relatives? _____
- ☐ Cancer -- What cancer(s) / Which relative(s)? _____

OTHER COMMENTS:

_____

_____

Patient Signature _____