Male History

Name: ____DOB:________________

PATIENT HISTORY QUESTIONNAIRE

Reason for this visit: ____

Referring Physician/How did you hear about us? ____

Occupation: ____

Preferred phone number: __________________________ Confidential voice mails OK: ☐ Yes ☐ No

Partners Name: ____ ☐ None Age of partner: _________
Last First Occupation of partner: ______________

Marital Status: ☐ Single ☐ Married ☐ Long term relationship ☐ Divorced ☐ Widowed

SEXUAL HISTORY

Do you have a sexual partner? Yes ☐ No ☐ (Male ☐ Female ☐)
Are there concerns about your sexual activity which you may want to discuss with your doctor?
Yes ☐ No ☐

PAST SURGICAL HISTORY

List all surgeries and their year: ☐ None

Surgeries Year

____ ______________

____ ______________

____ ______________

OTHER PAST HISTORY

Check any that apply:
☐ None ☐ Venereal warts ☐ Herpes-genital ☐ Syphilis ☐ Chlamydia ☐ Gonorrhea
☐ Other____

PAST MEDICAL HISTORY

Check any that apply:
☐ Arthritis ☐ Kidney Disease ☐ Asthma ☐ Gallstones ☐ Emphysema

☐ Liver Disease ☐ Bronchitis ☐ Epilepsy ☐ HIV+ ☐ High blood pressure

☐ Blood Transfusions ☐ Heart disease ☐ Thyroid disease ☐ Diabetes

☐ Controlled diet ☐ Pill controlled ☐ Insulin controlled

☐ Other_____

____

Do you currently?

☐ Smoke ☐ Yes ☐ No ____ packs/day

☐ Use alcohol ☐ Yes ☐ No
___ Wine (glasses/day) ___ beer (bottles/day) ___ hard liquor (oz. /day)

☐ Use illicit drugs ☐ Yes ☐ No ______________ type __________________ amount

☐ Exercise: Type:_______________________ How often _____________________

DRUG ALLERGIES

☐ Yes ☐ No
List:____

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FAMILY HISTORY	**Relative Affected**	**Age Diagnosed**
☐ Diabetes		
☐ Heart Disease		
☐ Colon Cancer		
☐ Prostate Cancer		
☐ Other		

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PATIENT SIGNATURE **DATE**

Email to: smile@crwhealth.com