Male STD Visit Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I use condoms (please circle): Always Sometimes Never

Medications:

Please list all medications here including vitamins, supplements or herbs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications, latex, or dyes? Yes No

If yes, please list them here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History – please circle if you’ve had any of the following:

Anemia

Asthma

Auto-immune Disorder like Lupus, Rheumatoid Arthritis, Multiple Sclerosis, Psoriasis or other

Penile, testicular or prostate problems

Cancer

Clotting disorders

Heart Disease, heart murmur, blood pressure problems or high cholesterol

Depression or mental health diagnosis

Diabetes

Gallbladder problems

Liver conditions or Hepatitis

Kidney or urinary tract problems

Migraines

Thyroid problems

Surgeries (please provide age &/or year done if you recall) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials & date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History – please circle any that apply to your blood relatives -- Mom, Dad, Sister/Brother, Aunt, Uncle, cousin, or Maternal & Paternal Grandparents.

Alcoholism or Drug abuse

Asthma, Allergies or Eczema

Autoimmune Disorder like Lupus, Rheumatoid Arthritis, Multiple Sclerosis, Psoriasis or other

Cancer (breast, ovarian, uterine, colon, skin, etc.)

Heart disease, Heart Attack, High Blood Pressure, High Cholesterol or Stroke

Blood clots in lung or legs, bleeding disorders, Anemia or Sickle Cell

Depression, mental health diagnosis or Suicide

Diabetes

Genetic disorders

Kidney disorders

Seizures

Thyroid problems

Any Men’s Health problems – Prostate or testicular

Personal Habits:

Do you use nicotine products like cigarettes, cigarillos or cigars? Yes No

Do you vape? Yes No

Do you drink alcohol? Yes No

If Yes, what do you drink (beer, wine, liquor, mixed drink, seltzer)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Yes, how often do you drink? Rarely, monthly, bimonthly, weekly or ­­­­\_\_\_\_\_\_\_\_days per week.

If Yes, how many drinks will you have in a 24hour period (1 drink is equal to 12oz. beer, 5oz. wine or 1.5oz. shot)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Yes, how many times in the last year have you drank more than 4 drinks in a 24hour period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any drug use? Yes No

If Yes, what kind of drug(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials & date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any caffeine intake? Yes No

If Yes, what type – coffee, tea, soda, energy drinks, other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Yes, how many cups daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any changes in sleep patterns? Yes No

How many hours do you usually sleep at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your activity level moderate, sedentary or vigorous? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your exercise frequency – 2-3x per week, 3-4x per week, daily, occasional or never? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_