



PATIENT HISTORY FOR MALE HEALTH MAINTENANCE EXAM

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Today's date: \_\_\_/\_\_\_/\_\_\_

Please list all Prescription Medications/Over-the-counter/Vitamins/Supplements you are currently taking:

Table with 5 columns: Medication Name, Strength, Frequency, Reason for medication, Refill needed? (Y/N)

List any Medication Allergies you may have:

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

SOCIAL HISTORY

Occupation: \_\_\_\_\_ Occupational hazards? \_\_\_\_\_
Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Life Partner [ ] Other: \_\_\_\_\_
Who lives in your home? [ ] Live Alone [ ] Spouse [ ] Children: \_\_\_\_\_ [ ] Father [ ] Mother [ ] Other: \_\_\_\_\_
Do you use Tobacco? [ ] Never [ ] Current user [ ] Former user Type: [ ] Cigarettes [ ] Chew [ ] Pipe [ ] Other: \_\_\_\_\_
Units/day: [ ] .5 [ ] 1 [ ] 1.5 [ ] 2 [ ] Other: \_\_\_\_\_ Years used: \_\_\_\_\_ Years quit: \_\_\_\_\_
Do you drink Alcohol? [ ] No [ ] Yes [ ] Formerly How many drinks per week? [ ] 1-3 [ ] 4-6 [ ] 7-10 [ ] Other: \_\_\_\_\_
Do you drink Caffeine? [ ] No [ ] Yes Type of Caffeine: [ ] Soda [ ] Coffee [ ] Energy drinks [ ] Other: \_\_\_\_\_ Amount/day: \_\_\_\_\_

LIFESTYLE

Type of exercise: \_\_\_\_\_
Exercise Frequency: [ ] 2-3 times/week [ ] 3-4 times/week [ ] Daily [ ] Never [ ] Occasionally Hours/week: [ ] 0-5 [ ] 5-10 [ ] 10-15
Do you have a religious affiliation [ ] Y [ ] N Religion: \_\_\_\_\_ Is religion/spirituality an important part of your life? [ ] Y [ ] N
Do you practice your religion? [ ] Y [ ] N Do you agree to transfusion? [ ] Y [ ] N

HOME ENVIRONMENT/SAFETY

Do you have smoke detectors in your home? [ ] Y [ ] N Pool/ spa at home? [ ] Y [ ] N
Do you have carbon monoxide detectors in your home? [ ] Y [ ] N Type of home heating? [ ] Gas [ ] Coal [ ] Electric [ ] Solar
Falls in the last year? [ ] Y [ ] N Number of falls: \_\_\_\_\_ Radon in the home? [ ] Y [ ] N
Firearms at home? [ ] Y [ ] N Number of firearms? \_\_\_\_\_ Locked storage? [ ] Y [ ] N
Do you use a seatbelt in the car? [ ] Always [ ] Never [ ] Occasionally

HEALTH MAINTENANCE

Date of last checkup: \_\_\_/\_\_\_/\_\_\_ Have you ever had a Colonoscopy? [ ] Y [ ] N Date: \_\_\_\_\_
Have you ever had a sexually transmitted disease? [ ] Y [ ] N If so, which one? \_\_\_\_\_
What are you doing to prevent getting HIV or a sexually transmitted disease? \_\_\_\_\_
Date of last prostate exam? \_\_\_/\_\_\_/\_\_\_ Have you had a PSA test? [ ] Y [ ] N Date: \_\_\_\_\_ [ ] Normal [ ] Abnormal
How many glasses of milk do you drink a day? [ ] 1 [ ] 2 [ ] 3 [ ] 5 [ ] 6+
Enter the most recent dates of the following immunizations:
Tetanus \_\_\_\_\_ Pneumonia \_\_\_\_\_ Flu \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Hepatitis A \_\_\_\_\_ MMR \_\_\_\_\_