HARRISON COUNTY HEALTH DEPARTMENT

MALE PATIENT HISTORY			
Patient Name:	Birth Date: / /	Pt. #	Date:
Address:	SS# _____		
City:	State/Zip		
Home Telephone: ( )	Alternate Telephone: ( )		
Name You would like us to call you:	Marital Status: Single ☐ Married ☐ Divorced ☐ Widow ☐		
Type of health insurance: Medical Card ☐ Number: _____ Self Pay ☐ Medicare ☐			
Name of Spouse/Partner:	Emergency Contact:		
	Relationship:		
	Home Telephone: ( )		
Family doctor:	Highest Grade Completed in School:		
Why have you come to the Clinic today?			

Check "**YES**" or "**NO**" if you any of the following problems:	YES	NO	Clinic Notes
1. Do you have discharge from the penis?			
2. Do you have difficulty or painful urination?			
3. Do you have any sores or lesions on your penis or mouth?			
4. Do you have rashes anywhere on your body?			
5. Do you have any bumps or warts?			
6. Do you have abdominal pain?			
7. Do you have nausea and/or vomiting??			
8. Do you have a sore throat today?			
9. Do you have night sweats?			
10. Do you have problems with fatigue?			
11. Do you have allergies to any medications?			
12. Do you have Depression or emotional problems?			
13. Have you had surgery of any kind?			
14. Have you been admitted to the hospital ever?			
15. Any recent changes in your health?			
16. Have you received a blood transfusion or blood products past year?			
17. Do you think your current partner relationship safe?			
18. Experienced physical, sexual or emotional abuse?			
19. How long have you been with your current sex partner? _____ (days, weeks, months, years)			
20. Number of partner(s) past year? 1 2 3 4 5 or more?			
21. Sexual contact you have with your current partner is: Vaginal ☐ Oral ☐ Rectal ☐			
22 Do you or your partner: Use IV drugs ☐ Have other sex partners ☐ Bisexual ☐ Have a STD, HIV or Hepatitis B or C ☐			
23. Do you use tobacco products? How long? _____ How much? _____ Do you use alcohol or drugs? Type: _____ How long? _____ How much? _____			
24. How do you protect yourself from sexually transmitted diseases?			
25. **Family Plan:** Do you plan to have/father children in the future?Yes ☐ No ☐ If yes, when ? _____ If no, how are you preventing pregnancy? _____ Have you ever fathered a child? Yes – Planned ☐ Yes – Unplanned ☐ No ☐ Do you need any further information about: Reproductive concerns ☐ Sexual Health concerns ☐ HIV/STD concerns ☐ Family planning concerns ☐ Other:			
26. Do you have any special needs or physical disabilities? Yes ☐ No ☐ (If yes, please explain)			
27. Do you take any medications over-the-counter or prescribed? Yes ☐ No ☐ (If yes, please explain)			

Client Signature _____ Date _____

Intake Nurse's Signature _____ Date _____

Written: 6/12