1. Last Name			First Name							MI
2. Patient Number										
3. Date of Birth (MM/DD/YYYY)										
			Month			Day			Year	
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White										
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported										
6. Gender ☐ Female ☐ Male										
7. County of Residence										
8. Home Address:						9. Marital Status:				

CONFIDENTIAL

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

MALE REPRODUCTIVE HEALTH HISTORY

Date: _____

A. GENERAL INFORMATION (Please complete the following)

1. What is the reason for your visit today? _____
2. Emergency contact: _____
3. May we contact you by mail? ☐ Yes ☐ No By phone? ☐ Yes ☐ No Your phone number is _____
4. Do you have a primary care provider? ☐ Yes ☐ No If yes, who? _____
5. Highest grade completed in school _____
6. Occupation _____
7. Special Needs/Primary Language _____

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: _____
2. Medications: Do you take any medications (prescription or over the counter), diet or herbal supplements? □ Yes □ No If yes, what?
   _____
3. Self and Family Medical History: Put an **X** under **SELF** and/or **X** under **FAMILY** (parent, grandparent, brother, sister or your child)

SELF	FAMILY		SELF	FAMILY	
☐	☐	1. Anemia/Sickle Cell Disease or Trait/Blood disorder	☐	☐	9. Hepatitis/Liver problems
☐	☐	2. Heart disease	☐	☐	10. Migraine headaches
☐	☐	3. Diabetes	☐	☐	11. Cancer
☐	☐	4. Hypertension/High cholesterol	☐	☐	12. Blood clots in legs or lungs
☐	☐	5. Thyroid/Endocrine	☐	☐	13. Mental illness/Emotional disorders
☐	☐	6. Pulmonary Disease	☐	☐	14. Transfusions of blood or blood products
☐	☐	7. Kidney Disease	☐	☐	15. Birth defects/Genetic problems
☐	☐	8. Seizure Disorders	☐	☐	16. Tuberculosis

If yes to any of the above, please explain: _____
_____
_____
_____

C. SEXUAL HISTORY (This section lends itself to being a self [patient completed] or a dialogue with the provider)

1. Do you have sex with? ☐ Men only ☐ Women only ☐ Both men and women
2. In the past two months, how many partners have you had sex with? _____
3. In the past 12 months, how many partners have you had sex with? _____
4. Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still in a sexual relationship with you? ☐ Yes ☐ No
5. What do you do to protect yourself from STDs and HIV? _____
6. What ways do you have sex? ☐ vaginal ☐ oral ☐ anal
7. Do you or your partner use condoms and/or dental dams every time you have vaginal, oral or anal sex? ☐ Yes ☐ No
8. Have you ever had an STD? (i.e., chlamydia, gonorrhea, trichomoniasis, herpes, syphilis, hepatitis B, others) ☐ Yes ☐ No
   If yes, which STD and when? _____
9. Have any of your partners had an STD? ☐ Yes ☐ No
   If yes, which STD and when? _____
10. Have you or any of your partners ever injected drugs? ☐ Yes ☐ No
11. Have you or any of your partners exchanged money or drugs for sex? _____
12. Have you had a HIV test ? ☐ Yes ☐ No If so, when? _____
13. Do you want a HIV test today? ☐ Yes ☐ No

D. SOCIAL/ENVIRONMENTAL HISTORY

1. Do you smoke, use smokeless tobacco or use electronic nicotine devices?
   ☐ Yes ☐ No If yes, how much? _____ How long? _____
2. Drink alcohol? ☐ Yes ☐ No If yes, how much? _____ How long? _____
3. Take street drugs? ☐ Yes ☐ No If yes, how much? _____ How long? _____
4. Are you regularly around someone else who uses alcohol, tobacco, electronic nicotine devices or street drugs?
   ☐ Yes ☐ No If yes, what do they use? _____ How often? _____

E. MENTAL HEALTH HISTORY

1. During the past two weeks, have you often been bothered by either of the following two problems?
   a. Feeling down, depressed, irritable or hopeless ☐ Yes ☐ No or
   b. Little interest or pleasure in doing things ☐ Yes ☐ No

F. IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES (UTD = up-to-date; REF = referred, and NA = not applicable)

Td/Tdap ☐ UTD ☐ REF ☐ NA	MMR ☐ UTD ☐ REF ☐ NA	Varicella ☐ UTD ☐ REF ☐ NA	HPV ☐ UTD ☐ REF ☐ NA	Hepatitis A ☐ UTD ☐ REF ☐ NA
Hepatitis B ☐ UTD ☐ REF ☐ NA	Meningococcal ☐ UTD ☐ REF ☐ NA	Pneumonia ☐ UTD ☐ REF ☐ NA	Influenza ☐ UTD ☐ REF ☐ NA	

Source of Information: ☐ NCIR ☐ Patient ☐ Other Written Documentation

Interviewer's Signature: _____ Date: _____

Signature of Interpreter (if used): _____ Date: _____