***CONFIDENTIAL***

North Carolina Department of Health and Human Services Division of Public Health

Place Patient Label Here

Reproductive Health Section

**BIOLOGICAL MALE REPRODUCTIVE HEALTH HISTORY**

Date:

1. **GENERAL INFORMATION** 
   1. May we contact you by mail? □ Yes □ No By phone? □ Yes □ No Your phone number is
   2. Do you have a primary care provider? □ Yes □ No If yes, who?

If No a referral to a primary care provider is offered □ Yes □ No

* 1. Hearing, visual, language and/or physical accommodation needs/Primary Language(s)
  2. Highest grade completed in school

# MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

* 1. List hospitalizations, surgeries and dates:
  2. Medications: Do you currently take any medications (prescription or over the counter), diet or

herbal supplements? □ Yes □ No If yes, what?

* 1. 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. | Heart disease/vascular problems (blood clots) | □ | □ | 7. | Liver Disease |
| □ | □ | 2. Sickle Cell Disease or Trait/Blood Disorder | | □ | □ | 8. | Migraine Headache (with aura) |
| □ | □ | 3. | Diabetes | □ | □ | 9. | Cancer |
| □ | □ | 4. | High Blood Pressure /High cholesterol | □ | □ | 10. . | Mental Illness/Emotional Disorders |
| □ | □ | 5. | Lung Disease | □ | □ | 11. | Other |
| □ | □ | 6. | Infertility |  |  |  |  |
|  | If yes to any of the above, please explain: | | | | | | |

# SOCIAL/ENVIRONMENTAL HISTORY

* 1. Do you currently use tobacco, including cigarettes, smokeless tobacco, electronic devices, or other products?
     + Yes □ No If yes, what type? How long?
  2. Drink alcohol? □ Yes □ No If yes, how much? How long?
  3. Use recreational drugs? □ Yes □ No If yes, what type? How often?

* 1. Are you regularly around someone else who uses alcohol, tobacco, electronic nicotine devices or recreational drugs?
     + Yes □ No If yes, what do they use? How often?

1. **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: | | | | |