***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:  |