

State of Alaska
 Department of Health and Social Services
 Section of Public Health Nursing
Male Reproductive Health History

Family Planning and sexually transmitted disease clinic services are confidential. No information is released without your consent except as may be required under public health and safety laws. You will be advised of any such reporting if it occurs. Information used for evaluation and planning purposes never includes personal identifiers.

Your age ___ Student No Yes School Attended _____ Highest level of education completed _____ Your occupation _____
 Marital status Single Married Living with Partner
 Medical Home - Name of Health Care Provider or Clinic _____ Date last seen _____
 Dental Home - Name of Dentist or Dental Clinic _____ Date last seen by Dentist _____ Date last seen by Dental Hygienist _____

Your Personal Health History

Any allergy to medicines and/or foods? No Yes Any allergy to latex? No Yes Don't Know
 List all medicines and foods you are allergic to and the reaction type _____
 Are you taking any prescription medicines, over-the-counter medicines, vitamins and/or supplements now? No Yes
 Please list _____
 Have you ever been hospitalized? No Yes Reason _____
 Have you ever had surgery? No Yes Reason _____
 Have you ever had a blood transfusion? No Yes Reason _____
 Have you had all required Alaska School shots (vaccinations)? Yes No Don't know
 If you were born before 1972, did your mother take diethylstilbestrol (DES) when pregnant with you? NA No Yes Don't Know

Please check 'Yes' for any condition listed below that you have now or had in the past, and please check 'No' if you 'never' had

Head & Neck	No	Yes	Additional Details or Comments	Gastrointestinal system	No	Yes	Additional Details or Comments
Thyroid condition				Gallbladder disease			
Other				Inflammatory bowel disease			
Breasts	No	Yes		Abdomen	No	Yes	
Lump or mass				Severe abdominal pain			
Nipple discharge				Hernia			
Pain				Genital-Urinary	No	Yes	
				Repeat urinary tract infection			
				Kidney disease			
Skin	No	Yes		Lymphatic system	No	Yes	
Rash/bumps/sores/warts				Swollen nodes			
Acne				Neurological system	No	Yes	
Tattoo(s)				Seizure disorder			
Body piercing(s)				Vision changes, blind spots			
Skeletal System	No	Yes		Headaches with vision changes, tingling or numbness			
Fractures "broken bones"							
Osteoporosis "bone loss"							
Heart & circulatory system	No	Yes		Miscellaneous	No	Yes	
High blood pressure				Active Liver Disease			
High cholesterol				<input type="checkbox"/> Tumor <input type="checkbox"/> Cirrhosis			
Anemia "low iron"				Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			
Heart disease				Diabetes Type 1 Type 2			
Heart attack				Cancer			Type?
Heart murmur				Asthma			Type?
				Autoimmune disease			Type?
				Tuberculosis disease			
				Other			What?

HR # _____ Name _____ B. Date _____ Sex _____ Race _____ Residence _____ Facility _____ Date _____ Time _____	Interviewer Comments (Please include initials, title and date)
--	---

Social and Lifestyle History			No	Yes	Family History			No	Yes	Age of Onset	
Do you exercise? Type _____ How often _____					Have your <i>immediate</i> family members had? Heart disease or attacks? <input type="checkbox"/> Before age 50 Mother / father / brother / sister						
Do you wear ? <input type="checkbox"/> seatbelts <input type="checkbox"/> helmets <input type="checkbox"/> life vests					Blood clots in legs or lungs? Stroke? mother / father / brother / sister <input type="checkbox"/> Age _____						
Has anyone ever touched you in a way that made you feel uncomfortable or forced you to have sex against your will?					High blood pressure needing medication mother / father / brother / sister						
Is verbal abuse or physical fighting making you feel unsafe at home?					Cancer Type _____ mother / father / brother / sister						
Do you, family or friends have concerns about your? <input type="checkbox"/> body weight <input type="checkbox"/> eating habits / diet <input type="checkbox"/> nutritional intake					Diabetes Type 1 Type 2 Age _____ mother / father / brother / sister						
Do you have feelings of sadness, fatigue, and/or anxiety that affect your ability to enjoy daily activities?					Mental Health Concerns? mother / father / brother / sister						
Do you have thoughts of harming yourself or others?					Alcohol / drug use <input type="checkbox"/> Past <input type="checkbox"/> Present mother / father / brother / sister						
Do you use tobacco? Type? Amount and frequency of use? _____					STD and HIV Risk History Last sexual exposure? Date _____ <input type="checkbox"/> oral <input type="checkbox"/> vaginal <input type="checkbox"/> anal						
How frequently do you use alcohol? type _____ frequency _____ amount _____					Did you use a condom during your last sexual encounter? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Do you use any recreational/street drugs? type(s) _____ frequency _____ amount _____					Have you had a new sexual partner in the last 2 months? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Reproductive Health History						Your usual frequency of condoms use <input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Always					
Have <i>you</i> ever had any of the following? If so, what and when?			No	Yes	What/ When	Number of sexual partners in the last 2 mos _____ 6 mos _____ 12 mos _____					
						Last Chlamydia screen Date _____ <input type="checkbox"/> Never had screening					
						Last HIV screen Date _____ <input type="checkbox"/> Never had screening					
Sexually transmitted infections <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis						Do you have sex with <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Both					
						What are you doing to protect yourself from STI and HIV _____					
Procedure(s) on the skin of the penis <input type="checkbox"/> Chemical <input type="checkbox"/> Cryo <input type="checkbox"/> Laser <input type="checkbox"/> Other						Questions About Your Sexual Partner Does <i>your sex partner</i> ?			No	Yes	Don't know
Procedure(s) on the skin of the scrotum <input type="checkbox"/> Chemical <input type="checkbox"/> Cryo <input type="checkbox"/> Laser <input type="checkbox"/> Other						Use a condom					
Procedure(s) of the anus / rectum						Now have or ever had a STD					
						Now have signs or symptoms of an STD					
						Have HIV infection					
						Currently injects drugs or history of use					
						Currently or previously has exchanged money or drugs for sex					
Fathered number of: Pregnancies _____ Full term births _____ Preterm births _____ Miscarriages _____ Abortions _____ AGE when fathered first pregnancy _____						Had a blood transfusion Year _____					
						Have other sex partner(s)					
						Have sex with <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both Male and Female <input type="checkbox"/> Don't know					
Interviewer Comments (Please include initials, title and date)						Your Current Concerns or Symptoms					
						Do you have any of the following now?			No	Yes	Comments
						Concern now about causing an unplanned pregnancy					
						Discharge from penis					
						Rash, bumps, warts, sores, itching on penis					
						Rash, bumps, warts, sores, itching on scrotum					
						Rash, bumps, warts, sores, itching of anus/rectum					
						Discharge from anus/rectum					
						Swelling in testicles					
						Burning or pain when urinating					
						Pain during sex					
Pre-Conception Health Planning											
Are you and a female partner planning a pregnancy in the next 6-12 months? <input type="checkbox"/> Unsure <input type="checkbox"/> No <input type="checkbox"/> Yes											
Has a female partner had difficulty getting pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes, have <i>not</i> been able to get pregnant after 12 months of seeking pregnancy											
What method(s) of birth control have <i>you</i> used in the past ? <input type="checkbox"/> Condoms <input type="checkbox"/> Abstinence <input type="checkbox"/> Vasectomy <input type="checkbox"/> None <input type="checkbox"/> Partner's											
What method(s) have <i>you</i> used in the past month ? <input type="checkbox"/> Condoms <input type="checkbox"/> Abstinence <input type="checkbox"/> Vasectomy <input type="checkbox"/> None <input type="checkbox"/> Partner's											
Are you interested in learning more about what you and a female partner can do to plan for a healthy pregnancy in the future? <input type="checkbox"/> No <input type="checkbox"/> Yes											
Is there anything else you would like us to ask or know about your health? <input type="checkbox"/> No <input type="checkbox"/> Yes What _____											
I consent to receive medical care for family planning and sexually transmitted disease screening/treatment services by professionally licensed staff of this Agency. I understand this may include physical examination, laboratory testing, and prescriptions. I have the right and will be provided with the opportunity to ask questions about my care, participate in the plan for my care, and to refuse services at any time without penalty.											

Client Signature _____ Interviewer Signature/Title _____ Date _____