Men's Health Questionnaire for New Patient and for Annual Wellness Visit

Name: _____Date of Birth: _____Today's Date: _____
Reason for Today's Visit: _____
Primary Care Provider: _____Pharmacy: _____ Pharmacy Location: _____
New Patient to GRPC: ☐ Yes ☐ No New Patient to this provider: ☐ Yes ☐ No Do you have Advance Directives: ☐ Yes ☐

PAST MEDICAL HISTORY (Please check all that apply and indicate family member – M=mother, F= father, B=brother, S=sister):

Thyroid Disease	Myself: ____	Family:____ Who? _____	Asthma	Myself: ____	Family:____ Who? _____
Heart Attack or Coronary Artery Disease	Myself: ____	Family:____ Who? _____	Seizure Disorder	Myself: ____	Family:____ Who? _____
Blood Clots	Myself: ____	Family:____ Who? _____	CVA (stroke)	Myself: ____	Family:____ Who? _____
High Blood Pressure (Hypertension)	Myself: ____	Family:____ Who? _____	Rheumatoid Arthritis	Myself: ____	Family:____ Who? _____
High Cholesterol (Hyperlipidemia)	Myself: ____	Family:____ Who? _____	Fibromyalgia	Myself: ____	Family:____ Who? _____
Ulcerative Colitis	Myself: ____	Family:____ Who? _____	Osteoporosis	Myself: ____	Family:____ Who? _____
Gallstones	Myself: ____	Family:____ Who? _____	Alcoholism	Myself: ____	Family:____ Who? _____
Crohn's Disease	Myself: ____	Family:____ Who? _____	Drug Addiction	Myself: ____	Family:____ Who? _____
Irritable Bowel Syndrome	Myself: ____	Family:____ Who? _____	Depression/ Anxiety	Myself: ____	Family:____ Who? _____
Hepatitis	Myself: ____	Family:____ Who? _____	Bipolar/ Schizophrena ADD/ADHD	Myself: ____	Family:____ Who? _____
COPD	Myself: ____	Family:____ Who? _____	Breast Cancer	Myself: ____	Family:____ Who? _____
Stomach Ulcer or Reflux Disease	Myself: ____	Family:____ Who? _____	Ovarian Cancer		Family:____ Who? _____
Kidney Stones	Myself: ____	Family:____ Who? _____	Cervical Cancer		Family:____ Who? _____
Frequent Urinary Infections	Myself: ____	Family:____ Who? _____	Skin Cancer	Myself: ____	Family:____ Who? _____
Diabetes	Myself: ____	Family:____ Who? _____	Colon Cancer	Myself: ____	Family:____ Who? _____
Migraines	Myself. ____	Family. ____Who? _____	Other:_____	Myself: ____	Family:____ Who? _____

Mother: ☐ Alive, age ____ ☐ Deceased at age ____ cause of death: _____
Father: ☐ Alive, age ____ ☐ Deceased at age ____ cause of death: _____

PAST SURGERY HISTORY (Please check all that apply and indicate year):

Tonsillectomy			Exploratory Laparoscopy		
Thyroidectomy			Exploratory Laparotomy		
Gallbladder Removal			Cosmetic Surgery		
Appendectomy			Varicose Vein Stripping		
Inguinal Hernia Repair			Bariatric Surgery		
Hemorrhoidectomy			Prostate Surgery		
Joint Replacement			Vasectomy / Sterilization		
Knee Arthroscopy			Neck or Back Sugery		
Rotator Cuff Repair			Other:		
Carpal Tunnel Release			Other:		
Colonoscopy			Other:		

Are you sexually active? ☐ Yes ☐ No
Sexual Preference: ☐ heterosexual ☐ homosexual ☐ bisexual
Recent New Partner (< 1 year)? ☐ Yes ☐ No

Have you ever had any STDs? (Please check all that apply and indicate year):

Chlamydia			Trichomonas		
Gonorrhea			HIV		
Herpes			Hepatitis B		
HPV			Hepatitis C		
Syphilis			Never had any		

Date of last bone density? _____ ☐ normal ☐ low bone density ☐ Osteoporosis ☐ have not had one done
When was your last TDap shot? _____When was your last cholesterol check? _____
Last Dental Visit/Where?_____ Last Vision Screening/Where?_____ Last Hearing Test_____
Communication requirements due to hearing, vision, or cognition? ☐ Yes ☐ No Explain: _____

SOCIAL HISTORY:
Occupation: _____ Highest level of education or grade completed:_____ Second hand smoke exposure? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes How many years? ____ How many packs per day? ____ ☐ Never ☐ Not anymore, I quit ____ years ago.
Do you drink alcohol? ☐ Yes How many drinks per week? ____ Type: _____ ☐ Never ☐ Not anymore, I quit ____ years ago.
Do you use recreational drugs (marijuana) or illicit drugs? ☐ Yes ☐ No Type: _____
Do you have difficulty interacting socially? ☐ Yes ☐ No Explain:_____
Housing/living situation concerns (safety issues, access to healthy food, transportation problems)☐ Yes ☐ No Explain:_____
Trauma history (physical/emotional/sexual abuse, PTSD,other) ☐ Yes ☐ No Explain:_____

MEDICATIONS: (Prescriptions, Vitamins, Herbal/Alternative Meds)
Are you allergic to any medications? ☐ Yes ☐ No What? _____
List any medications you are taking including prescription, over the counter, vitamins, and herbal/alternative meds:

Current Medication and indication	Dosage	Prescribed by:

Do you have trouble affording the care or prescriptions prescribed? ☐ Yes ☐ No Explain:_____

Patient Signature: _____ Date_____