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? __________	Rheumatoid Arthritis	Myself: ____	Family:____ Who? _______
Heart Attack or Coronary Artery Disease	Myself: ____	Family:____ Who? __________	Fibromyalgia	Myself: ____	Family:____ Who? _______
Blood Clots	Myself: ____	Family:____ Who? __________	Osteoporosis	Myself: ____	Family:____ Who? _______
High Blood Pressure	Myself: ____	Family:____ Who? __________	Alcoholism	Myself: ____	Family:____ Who? _______
High Cholesterol	Myself: ____	Family:____ Who? __________	Drug Addiction	Myself: ____	Family:____ Who? _______
Ulcerative Colitis	Myself: ____	Family:____ Who? __________	Depression	Myself: ____	Family:____ Who? _______
Gallstones	Myself: ____	Family:____ Who? __________	Anxiety	Myself: ____	Family:____ Who? _______
Crohn's Disease	Myself: ____	Family:____ Who? __________	Bipolar	Myself: ____	Family:____ Who? _______
Irritable Bowel Syndrome	Myself: ____	Family:____ Who? __________	Schizophrenia	Myself: ____	Family:____ Who? _______
Hepatitis	Myself: ____	Family:____ Who? __________	ADD/ADHD	Myself: ____	Family:____ Who? _______
COPD	Myself: ____	Family:____ Who? __________	Breast Cancer	Myself: ____	Family:____ Who? _______
Stomach Ulcer or Reflux	Myself: ____	Family:____ Who? __________	Ovarian Cancer	Myself: ____	Family:____ Who? _______
Kidney Stones	Myself: ____	Family:____ Who? __________	Cervical Cancer	Myself: ____	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? _______
Asthma	Myself: ____	Family:____ Who? _______	Other:______	Myself: ____	Family:____ Who? _______
Seizure Disorder	Myself: ____	Family:____ Who? _______	Other:______	Myself: ____	Family:____ Who? _______
CVA (stroke)	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 Colonoscopy?_____________________ ☐ normal ☐ abnormal ☐ have not had one done
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:

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

Patient Signature: ____ Date___________________________