



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 No

Disability Status: Yes No If yes, please explain: _____

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 Surgery		
Rotator Cuff Repair			Other:		
Carpal Tunnel Release			Other:		
Colonoscopy			Other:		

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: _____

Gender Identity: Male Female Trans Male/Trans Man Trans Female/Trans Women Genderqueer/Gender Nonconforming
 Other Identity _____
 Sexual Preference: heterosexual/straight homosexual bisexual other _____
 Are you sexually active? Yes No
 Recent New Partner (< 1 year)? Yes No

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 _____