WOMEN'S MEDICAL CENTER

Health History Form - Male

Name: _____ DOB: _____ Age: _____

Marital Status: _____ Occupation: _____

Highest Grade Finished: _____ Ethnicity (please circle): African American Caucasian Hispanic Asian American Native American Ashkenazi Jewish Other: _____

Religion (please circle): Christian Baptist Latter-day Saints Catholic Lutheran Mormonism Judaism Islam Buddism Hinduism Muslim Non-Religious Atheist

Do you exercise? Yes No If yes, what type of exercise? _____

Do you smoke? Yes No Do you drink alcohol? Yes No Do you use Medical Marijuana? Yes No

Have you ever used any type of illegal drugs? Yes No Type: _____

Do you wear your seatbelt: Yes No Do you feel safe at home: Yes No

Do you have Advance Directives: Yes No Do you want information about Advance Directives: Yes No

Have you recently had the following vaccines: HPV/Gardasil Flu Pneumonia Shingles Tetanus

Your Personal History (please check all that pertain):

Asthma/Lung Disease		Diabetes		Fracture			Sexual Issues		
Bleeding Disorders		Gallstones		Kidney Disease			Thyroid Disease		
Breast Cancer		Genital Herpes		Liver Disease			Urinary Issues		
Cervical Cancer		Heart Disease		Lupus/Autoimmune			Uterine Cancer		
Colon Cancer		Hematological Disease		Ovarian Cancer					
Depression/Mental Disease		High Blood Pressure		Pelvic Infection/STD					

Family History (list family member):

Alcohol/Drug Abuse _____ Bleeding/Blood Clots _____

Breast Cancer _____ BRCA Mutation; Cancer Syndrome _____

Colon Cancer _____ Diabetes _____

Heart Disease _____ Ovarian Cancer _____

Other _____

Name:_____ Date:_____

Name of Pharmacy:_____

Allergies

Medication Allery & Reaction	Food Allergy & Reaction	Environmental Allergy & Reaction

Prescription Medications (including Medical Marijuana)

Medication Name	Dose	Frequency	How long have you taken?	Prescriber

Over-The-Counter Medications (include all pills, liquids, topical creams, etc)

Medication	How often	Used for?

Surgical History

Date	Type

WE CARE FOR ALL WOMEN AT ALL TIMES

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BHRT Checklist For Men

Name: _____ Date: _____

E-Mail: _____ HT: _____ WT: _____ BMI: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

Heart Disease				
Diabetes				
Osteoporosis				
Alzheimer's Disease				