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 attending _____ Highest grade completed _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widower ☐ Living with partner Your occupation _____

Name of your Health Care Provider or Clinic Date last seen

Have you seen a Dentist in the past year? ☐ Yes ☐ No

What is the reason for your visit today?

Your Personal Health History

	No	Yes	List	What was the reaction?
Allergy to medications?				
Other allergies?				
Allergy to latex?				
Are you taking any prescription or over the counter medications, vitamins and/or supplements?				
Have you ever been hospitalized?				
Have you ever had surgery?				

Please check box **C** ***Current*** (*if you currently have*) or **P** **for *Past*** (if you have ever had) any of the following Medical Conditions

	C	P		C	P		C	P		C	P
Diabetes ☐ Type 1 ☐ Type 2			Gallbladder disease			Testicular pain			Abnormal discharge from penis		
Thyroid condition			Kidney disease			Genital Herpes			Severe abdominal pain		
Breast ☐ pain ☐ nipple discharge			Inflammatory bowel disease			Syphilis			Sore throat		
Cancer (types)			Hernia			Gonorrhea			Headaches		
Anemia "low iron"			Liver problems ☐ Tumor ☐ Cirrhosis			Chlamydia			Seizure disorder		
High blood pressure			Hepatitis Type ☐ A ☐ B ☐ C			Other STI's			Autoimmune disease		
Stroke			HIV/AIDS			Skin: ☐ rash ☐ bumps ☐ sores			Multiple sclerosis		
Blood clot ☐ legs ☐ lungs			Cryptorchidism			Swollen lymph nodes			Tuberculosis		
Heart ☐ disease ☐ attack			Varicocele			Pain during ejaculation			Mumps		
High cholesterol			Testicular torsion			Problems with urination ☐ pain ☐ burning			Exposure to environmental ☐ hazards ☐ toxins		

☐ I have no current or past medical conditions Other medical conditions not listed above:

Family History

(please put an X in the boxes for family members if they have or have had the following medical conditions, please describe in comment box)

Medical Condition	Mother	Father	Sister	Brother	Comments
Blood clot in ☐ legs or ☐ lungs					
Cancer: **Type** (write under comments)					
Mental Health Concerns ☐ Past ☐ Present					
Problems with Alcohol ☐ Past ☐ Present					
Problems with drugs ☐ Past ☐ Present					

☐ My family has none of the above conditions ☐ I don't know my family history: ☐ adopted ☐ not living with parents ☐ other

HR# _____

Name _____

Birth Date _____ Sex _____

Residence _____

Facility _____

Date _____

Interviewer updates (include date, name & credentials)

Form 06-1625 (Rev 01/18)

Reproductive Health History / Preconception Health Planning

Number of children fathered. _____

Are you and your partner planning a pregnancy in the next 6 - 12 months? ☐ No ☐ Yes

Are you and your partner having difficulty getting pregnant? ☐ No ☐ Yes ☐ Haven't tried

What method(s) have **you** used in the ***past*** to prevent pregnancy? ☐ Condom ☐ Withdrawal ☐ Abstinence ☐ Vasectomy ☐ None

What method (s) are **you** currently using to prevent pregnancy? ☐ Condom ☐ Withdrawal ☐ Abstinence ☐ Vasectomy ☐ None **OR**
My partner uses ☐ Pill ☐ Shot ☐ Patch ☐ Ring ☐ IUD ☐ Implant ☐ Natural ☐ Sterilization ☐ Unsure

Social and Lifestyle History

	No	Yes		No	Yes
Do you use Tobacco? Type(s)_____Amount per day_____			Do you have feelings of sadness, fatigue and/or anxiety that affect your ability to enjoy daily activity?		
Do you drink alcohol? Type(s)_____Amount_____Frequency_____			Do you have thoughts of harming yourself or others?		
Do you use any recreational/street drugs? Type(s)_____Amount_____Frequency_____			Is verbal abuse or physical fighting making you feel unsafe?		
Do you wear ☐ seatbelts ☐ helmets ☐ life vests			Has anyone ever touched you in a way that made you feel uncomfortable or forced you to have sex against your will?		

Comments:

Sexual History

Questions about **You**	No	Yes	Questions about **Your Sexual Partner(s)**	No	Yes	Unsure
Are you currently sexually active or in a sexual relationship?			Use a condom?			
Have you had a **new** sexual partner in the past 2 months?			Currently has or ever had a STI?			
Did you use condoms during your last sexual encounter?			Currently has symptoms of a STI?			
Currently or previously traded sex for money, drugs or alcohol?			Currently or previously traded sex for money, drugs or alcohol?			
Have sex with ☐ Female ☐ Male ☐ Both Type of sex ☐ Oral ☐ Anal ☐ Vaginal			Currently or previously injected drugs?			
How often do you use a condom? ☐ never ☐ sometimes ☐ always			Currently have sex with other partners? If yes ☐ Male ☐ Female ☐ Both ☐ Unsure			
Number of sexual partners in the past 12 months_____2 months_____1 month_____			Partners **past** partners include: ☐ Male ☐ Female ☐ Both ☐ None ☐ Unsure			

Comments:

Is there anything else you would like us to know about your current or past medical / social or sexual history? ☐ No ☐ Yes (If yes please explain)

Do you have any concerns you want to discuss today? ☐ No ☐ Yes (If yes please explain)

Additional Interviewer Updates (include date, name, and credentials)

I consent to receive medical care for sexually transmitted infections and/or family planning services by professionally licensed staff of this Agency. I understand that this may include a physical examination, laboratory testing including STI/HIV screening, and prescriptions. I have the right to participate in my care, ask questions and refuse services at any time without penalty.

Client Signature_____Date_____Interviewer's Signature/Credentials_____Date_____