**Verdugo Internal Medicine**
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# MALE MEDICAL HISTORY INFORMATION FORM

**Patient Name:**_____ **Birthdate:** _____ **Date:**_____

Born and raised in: _____

**Patient's Past Medical History (Please Answer):**

| | Yes | No |
|---|---|---|
| Measles | | |
| Mumps | | |
| Chicken Pox | | |
| Scarlet Fever | | |
| Palpitations | | |
| Angina | | |
| Valvular Heart Disease | | |
| Arrhythmias | | |
| Hypertension | | |
| Heart Failure | | |
| Heart Attack | | |
| Heart Murmur | | |
| Strokes | | |
| Seizures | | |
| Migraines | | |
| Depression or Anxiety | | |

| | Yes | No |
|---|---|---|
| Bronchitis | | |
| Asthma | | |
| Emphysema | | |
| Pneumonia | | |
| Lung Cancer | | |
| Tuberculosis | | |
| Irritable Bowel Syndrome | | |
| Hepatitis | | |
| Crohn's Disease | | |
| Ulcerative Colitis | | |
| Diverticulosis | | |
| Constipation | | |
| Diarrhea | | |
| Hemorrhoids | | |
| Gallstones | | |
| Anorexia or Bulimia | | |

| | Yes | No |
|---|---|---|
| Hay Fever | | |
| Sinusitis | | |
| Glaucoma | | |
| Thyroid Disease | | |
| Diabetes | | |
| Kidney Stones | | |
| Kidney or Urine Infections | | |
| Anemia | | |
| Bleeding Disorder | | |
| Back Pain | | |
| Arthritis | | |
| Rheumatic Fever | | |
| Lupus | | |
| Skin Problems | | |
| Cancer | | |
| Sexually transmitted disease | | |

**List other medical history not noted above:**

_____

**List all surgeries with dates:**

_____

_____

_____

_____

**List all medications you are taking, including over the counter drugs:**

| Medication | Strength | Pills per Day | Date Medication Began |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**List any medications that you are allergic to or unable to tolerate and the reaction/side effect that you had with each:**

| **Medication:** | **Reaction or side effect** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**List recent travel:**

_____

_____

**Family history:**

| **Family Profile** | **Living** | **Died** | **Age** | **Cause of Death** | **Other Diseases** |
|---|---|---|---|---|---|
| Paternal Grandfather | | | | | |
| Paternal Grandmother | | | | | |
| Maternal Grandfather | | | | | |
| Maternal Grandmother | | | | | |
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| Sisters | | | | | |
| | | | | | |
| Children | | | | | |
| | | | | | |
| | | | | | |

**Do you have a family history of any of the following diseases?**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Tuberculosis | ___ | ___ | Seizure | ___ | ___ | High Blood Pressure | ___ | ___ |
| Asthma | ___ | ___ | Migraine | ___ | ___ | Heart Attack Before Age 60 | ___ | ___ |
| Hay Fever | ___ | ___ | Alcoholism | ___ | ___ | Stroke Before Age 60 | ___ | ___ |
| Emphysema | ___ | ___ | Cirrhosis | ___ | ___ | Bleeding Disorder | ___ | ___ |
| Diabetes | ___ | ___ | Arthritis | ___ | ___ | Osteoporosis/Hip Fracture | ___ | ___ |
| Obesity | ___ | ___ | Early Senility | ___ | ___ | Hepatitis B or C | ___ | ___ |
| Thyroid Disease | ___ | ___ | Depression | ___ | ___ | Cancer/Leukemia | ___ | ___ |

**Personal Weight History:**

Minimum Adult Weight: _____ Maximum Adult Weight: _____ Average Adult Weight _____

**List your other doctors:**

_____
_____
_____
_____
_____

**Social History:**
What is your occupation? _____ Do you enjoy your work? _____
Is it mildly, moderately or highly stressful? _____
Are you exposed to any chemicals, fumes, asbestos or toxins in your workplace? _____
Have you served in the military? If so, when and where:_____
Have you traveled out of the country? If so, when and where: _____

Are you single, married, divorced or widowed? _____ For how long? _____
If single, do you live with someone or have an ongoing relationship? _____
List your hobbies: _____
Do you exercise regularly? _____ How many times a week? _____
If so, what type of exercise? _____
Household pet(s) _____

Do you have a prior/present history of cigarette smoking? _____ How many packs per day? _____
How old were you when you started smoking? _____ Have you tried to quit? _____ If so, when? _____
Do you drink alcohol? _____ Do you drink coffee? _____
Do you have any prior/present history of drug abuse? _____
Are you on any special diet? _____

**Urologic history:**
Have you ever had undescended testicles? YES NO
Have you ever had a hernia repair? YES NO
Have you ever been diagnosed with a varicocele? YES NO
If you are sexually active what method of birth control do you use? _____
Have you had a vasectomy? YES NO
Do you have a problem with achieving erections? YES NO
Have you been diagnosed with benign prostate hypertrophy? YES NO
Do you have a weak urinary stream? YES NO
Do you feel it is difficult to postpone urination? YES NO
Do you have to get up a night to urinate? YES NO If yes, how many times? _____
Do you examine your testicles regularly? YES NO

**Please enter record of vaccinations:**
Last Tetanus _____
Flu _____
Pneumonia Vaccine _____
Hepatitis B _____ _____ _____
Rubella _____ _____ _____
Shingles _____
Have you ever had an allergic reaction to any vaccine? _____

## REVIEW OF SYSTEMS

**Do you have a significant problem with any of the following symptoms?**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ____ | ____ | Fever | ____ | ____ | Difficulty Swallowing |
| ____ | ____ | Chills | ____ | ____ | Heartburn, nausea, or vomiting |
| ____ | ____ | Night Sweats | ____ | ____ | Abdominal Pain |
| ____ | ____ | Weight Loss | ____ | ____ | Indigestion |
| ____ | ____ | Weight Gain | ____ | ____ | Cramping |
| ____ | ____ | Heat Intolerance | ____ | ____ | Diarrhea |
| ____ | ____ | Cold Intolerance | ____ | ____ | Constipation |
| | | | ____ | ____ | Mucous in Stool |
| ____ | ____ | Excessive Bleeding | ____ | ____ | Blood in Stool |
| ____ | ____ | Rashes | ____ | ____ | Dark or Black Stool |
| ____ | ____ | Itching | ____ | ____ | Change in Bowel Habits |
| ____ | ____ | Lumps | ____ | ____ | Pain/Discomfort with Urination |
| ____ | ____ | Changes in Moles | ____ | ____ | Excessive or Frequent Urination |
| | | | ____ | ____ | Urge to Urinate |
| ____ | ____ | Headaches | ____ | ____ | Loss of Urine with Cough, Laughing or Sneezing |
| ____ | ____ | Change in Vision | | | |
| ____ | ____ | Blurry or Double Vision | ____ | ____ | Other Accidental Loss of Urine or Stool |
| ____ | ____ | Decrease in Hearing | | | |
| ____ | ____ | Noises in Ears | | | |
| ____ | ____ | Vertigo | | | |
| ____ | ____ | Frequent Bloody Noses | ____ | ____ | Problem achieving erections |
| ____ | ____ | Nasal or Sinus Congestion | ____ | ____ | Weak urinary stream |
| ____ | ____ | Hoarseness | ____ | ____ | Is it difficult to postpone urination |
| ____ | ____ | Cough | ____ | ____ | Do you get up at night to urinate |
| ____ | ____ | Sputum | ____ | ____ | Have you noticed any lump on chest |
| ____ | ____ | Bloody Sputum | ____ | ____ | Pain or lump in testicles |
| ____ | ____ | Shortness of Breath With Minor Exertion | ____ | ____ | Pain or Stiffness of Joints (list) _____ |
| ____ | ____ | Chest Pressure | ____ | ____ | Back Pain |
| ____ | ____ | Chest Pain | ____ | ____ | Muscle Pain or Ache |
| ____ | ____ | Shortness of Breath When Lying Flat | ____ | ____ | Muscle Weakness |
| | | | ____ | ____ | Numbness in Arms or Legs |
| ____ | ____ | Unexplained Fatigue | | | |
| ____ | ____ | Ankle or Foot Swelling | ____ | ____ | Anxiety |
| ____ | ____ | Pounding or Skipping Heart | ____ | ____ | Depression |
| ____ | ____ | Lightheadedness | ____ | ____ | Difficulty Sleeping |
| ____ | ____ | Fainting | ____ | ____ | Loss of Appetite |
| ____ | ____ | Pain in Legs on Walking | ____ | ____ | Decreased Sex Drive |

**Any other information you feel relevant:**

_____

_____