MALE VISIT

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH – FAMILY PLANNING PROGRAM
SFN 8633 (5-2010)

Do you have a family doctor? ☐ No ☐ Yes-Name of Doctor _____	History Date:

The health history is an important part of your health care. If you have questions, please ask.

Yes	No	Self history questions	STAFF USE ONLY
		1. Do you have any allergies (food, medications, or latex)? If yes list:	
		2. Are you currently taking any type of medication (prescription or over-the-counter)? List:	
		3. Are you currently taking any type of herbals, diet pills, supplements, vitamins (St. John's Wort or Others)? List:	
		4. Are you having sex? ☐ men ☐ women ☐ vaginal ☐ anal ☐ oral If yes, how often do you use condoms? ☐ sometimes ☐ always ☐ never	
		5. How are you protecting yourself against HIV?	
		6. Have you ever been treated for a Sexually Transmitted Infection?	
		7. Have you noticed any signs of infection? ☐ bumps or sores ☐ burning ☐ discharge ☐ itching ☐ odor ☐ pain with sex ☐ rashes ☐ swelling ☐ testicular or abdominal pain ☐ other	
		8. How many sexual partners have you had in the last 60 days? _____ Lifetime? _____ Date of last intercourse? _____ Age of first intercourse? _____ Length of current relationship? _____	
		9. Have any of your past/present partners had a history of: ☐ Injectable drug use ☐ Multiple partners ☐ Bisexuality ☐ Sexually transmitted infections and/or HIV ☐ N/A	
		10. Have you had a blood transfusion or been exposed to any blood products?	
Staff Signature:			Date:

Yes	No	~~~~~~~~~~~~~~~~~~~ **COMPLETE BELOW ONLY IF INSTRUCTED TO DO SO** ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
		11. Have you had recent surgery, emergency room or clinic visits (in the past year)?	
		12. Do you have family history of prostate cancer?	
		13. Do you know how to do testicular self exam?	
		14. Have you noticed any changes in your complexion or any other skin problems?	
		15. Do you use tobacco? ☐ smoke ☐ chew If yes, number of cans/cigarettes per day? _____ How long have you been using tobacco? Months: Years: If yes, are you ready to quit or cut back on tobacco? ☐ Yes ☐ No Are you exposed to second-hand smoke? ☐ Yes ☐ No	Advised to quit? ☐ Yes ☐ No Referred? ☐ Yes ☐ No
		16. Do you use alcohol? If yes, how many drinks? _____ how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other	
		17. Have you ever used street drugs (marijuana, cocaine, crank, methamphetamine, other)? If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other	
		18. Have you received information on all forms of birth control including emergency contraception?	
		19. Have you ever fathered a child?	
		20. Do you use seatbelts? ☐ Always ☐ Sometimes	
		21. Do you have any questions or concerns regarding your growth and development?	
		22. Do you have any other questions or problems (health, sexuality, nutrition, etc.)?	

Name (Print)	Date of Birth	Client number

STAFF USE:

Reason for visit:	Immunizations Reviewed: ☐ Yes ☐ No	Victim Assessment:	Required Adolescent Counseling (parental involvement and avoidance of sexual coercion):	Pre-Exam Interview:

OBJECTIVE DATABASE x If Normal NA – not assessed

23. BP HT WT BMI		
24. ENT		
25. Thyroid		
26. Skin		
27. Breasts		
28. Heart		
29. Lungs		Waist Circumference
30. Abdomen		CVA Tenderness
31. External Genitalia		Circumcised
32. Lymphatic		
33. Inguinal Hernia		
34. Rectal exam		
35. Lower Extremities		
36. Prostate		
37. Other Findings		

Laboratory	X if Done	Results	Plans [Methods]
38. Hct or Hgb			44. ☐ Condoms
39. Gonorrhea Screen			45. ☐ NFP
40. Chlamydia Screen			46. ☐ Vasectomy
41. HIV Screen			47. ☐ Rely on partner method
42. Urine Analysis			48. ☐ Other
43. Other Lab (Specify)			

Comments:

Post - exam interview? Yes ☐ No ☐	Signature (Clinician)	Date

Reason for Visit

Name (Print)	Age	Date of Birth	Client Number