



**UNIVERSITY HEALTH SERVICES (UHS)  
PREVENTIVE HEALTH VISIT - MALE**

Date \_\_\_\_\_

Print Name (Last, First) \_\_\_\_\_

Social Security/ID Number \_\_\_\_\_

This form is confidential. Not all questions will be pertinent to every patient's situation. Please answer all questions on this page and the next page (to the double line). Please complete this form using a pen, not pencil.

Reason for visit \_\_\_\_\_ Age \_\_\_\_\_

Are you having any other concerns you would like addressed? \_\_\_\_\_

PERSONAL MEDICAL HISTORY

- |                          |                          |   |
|--------------------------|--------------------------|---|
| Yes                      | No                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia, bleeding disorder, phlebitis _____                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, seizures, convulsions _____                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches (frequent/severe), migraines _____                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease, high blood pressure, heart murmur _____                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Cholesterol checked date _____ value _____                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, hepatitis, gall bladder disease _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer, colitis, bowel disease _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression, suicide attempt _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary problem, kidney stone _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chickenpox  |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional problems  |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis, positive skin test for TB, last TB test date _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disorders _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Testicular problems/surgeries _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell disease/trait _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Infectious mononucleosis _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Back or extremity problem _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing/vision impairment _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental condition _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin condition _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Surgery if yes, explain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently under care for a medical condition? If yes, explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you on any regular medications? If yes, please list _____               |

FAMILY MEDICAL HISTORY

- |   |                          |  |
|---|--------------------------|--|
| Yes   | No                       |  |
| <input type="checkbox"/>  | <input type="checkbox"/> | Were you adopted? If NO, complete the following: |
| Have any of your immediate family (parents, sisters, brothers, children) had the following: |                          |  |
| Yes   | No                       |  |
| <input type="checkbox"/>  | <input type="checkbox"/> | Allergy  |
| <input type="checkbox"/>  | <input type="checkbox"/> | Cancer   |
| <input type="checkbox"/>  | <input type="checkbox"/> | Diabetes   |
| <input type="checkbox"/>  | <input type="checkbox"/> | High blood pressure                              |
| <input type="checkbox"/>  | <input type="checkbox"/> | Stroke   |
| <input type="checkbox"/>  | <input type="checkbox"/> | Heart disease                                    |
| <input type="checkbox"/>  | <input type="checkbox"/> | High cholesterol                                 |
| <input type="checkbox"/>  | <input type="checkbox"/> | Mental health problems                           |
| <input type="checkbox"/>  | <input type="checkbox"/> | Alcohol or other drug problems                   |
| <input type="checkbox"/>  | <input type="checkbox"/> | Tuberculosis                                     |
| <input type="checkbox"/>  | <input type="checkbox"/> | Migraine headache                                |
| <input type="checkbox"/>  | <input type="checkbox"/> | Seizures   |

IMMUNIZATION REVIEW

- Have you had or been vaccinated for:
- |                          |                          |   |
|--------------------------|--------------------------|---|
| Yes                      | No                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Measles, mumps, rubella vaccine (2 doses) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B complete                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Meningitis vaccine                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus shot within 10 years              |



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HEALTH BEHAVIOR

Yes No

- Has it been more than 1 month since you performed a testicular self exam?
- Do you have any questions about how to perform a testicular self exam?
- Has it been longer than 1 week since you have exercised? If you do exercise, how often? \_\_\_\_\_
- And do you exercise regularly? \_\_\_\_\_
- Have you ever taken anabolic steroids?
- Do you take dietary supplements such as creatine and androstenedione?
- Do you smoke \_\_\_\_\_ cigs/day for \_\_\_\_\_ years
- Do you chew tobacco/snuff?
- Do you drink alcohol? If yes, answer questions 1 - 10.
- 1) Do you feel you are a normal drinker? (That is, drink no more than average.)
- 2) Does your partner, close relatives or friends ever worry or complain about your drinking?
- 3) Are you always able to stop drinking when you want to?
- 4) Has your drinking ever created problems between you and your partner, parents, or other near relative or friends?
- 5) Do you ever drink in the morning?
- 6) Have you ever felt the need to cut down on your drinking?
- 7) Have you ever been told by a health care provider to stop drinking?
- 8) Have you ever been a patient in a psychiatric or rehab hospital or on a psychiatric ward of a general hospital?
- 9) If you answered YES to #8, was drinking or drug use part of the problem that resulted in your hospitalization?
- 10) Have you ever been arrested, even for a few hours, because of driving while intoxicated?

HEALTH BEHAVIOR

Yes No

- Do you have concerns about drug use?
- Do you have concerns about your weight and/or eating behavior?
- Do you ever ride in a vehicle without a seatbelt?
- Do you ride a bike without a helmet?
- Do you have firearms here at your local PSU residence?
- Have you ever been a resident or employed in the following?  
 prisons,  homeless shelters,  health care setting?
- Do you have concerns about your ability to handle stress?
- Do you feel sad or depressed frequently?
- Are you living in a place without a smoke detector?
- Do you use a tanning bed or sunbathe frequently?
- Do you have any concerns about physical or emotional abuse?
- If you gamble, have you had concerns about your ability to limit your gambling?

SEXUAL HISTORY

Yes No

- Have you ever had genital to genital contact?
- Your sexual partners are (circle one):  
male female both
- Have you had more than one partner in your lifetime?
- Do you use condoms 100% of the time?
- Sex partner with STD or urinary problems?
- Previous urethritis, epididymitis, prostatitis?
- Has anyone close to you had HIV or AIDS?

\_\_\_\_\_  
Patient Signature