



Prairie Clinic, S.C.
112 Helen Street
Sauk City, WI 53583

MALE HISTORY FORM

(Please take a few minutes to fill out this form. It, like all of your medical records, is confidential).

NAME: _____ DOB: _____ DATE: _____

I am at the clinic for: _____

List all previous surgeries and dates:

- 1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Any problems with (check all that apply):

- Diabetes _____ Blood pressure _____ Heart disease _____ Asthma _____
Cancer _____ High cholesterol _____ Thyroid disease _____ Anemia _____

List current and previous medical problems (other than above): _____

List previous serious injuries (broken bones, trauma, accidents): _____

Have you ever had a blood transfusion? No Yes When? _____

Current medications with dosage (include over-the-counter drugs, vitamins, herbs, etc.):

- 1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Have you ever used Vioxx, Celebrex or Bextra? No Yes (circle)

Have you ever used fenfluramine (pondimin) or dexfenfluramine (Redux) - "Fen-Phen?" No Yes

Allergies to medications?

No _____

Yes _____ What medicine? _____ Type of reaction: _____

Year of most recent: flu vaccine _____ tetanus vaccine _____ pneumonia vaccine _____

Do you perform testicular self-exams? Yes No

Do you have any problems urinating (hard to start, dribbling, or pain)? Yes No

Do you have any problems getting or maintaining an erection? Yes No

Do you see other types of health practitioners? (Chiropractor, acupuncturist, etc.) Yes No

If yes, for what reason? _____

Do you have a healthcare power of attorney? Yes No

Do you have a living will? Yes No

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FAMILY HISTORY

Mother: Living/Deceased Age: _____ Health Problems? _____
Father: Living/Deceased Age: _____ Health Problems? _____
Sisters/Brothers: Ages & Health Problems: _____

Please state who in your family has/had the following health problems:

Cancer (breast, colon, prostate, female, other): _____
High blood pressure: _____
High cholesterol: _____
Diabetes: _____
Other health problems: _____

OCCUPATION: _____

SOCIAL HISTORY

Married _____ Single _____ Widowed _____ Divorced _____
If married or in a long-term relationship, list age and occupation of partner:

Children (how old?): _____

HEALTH HABITS (How much and how long):

Tobacco (smoke/chew): No Yes _____
Alcohol: No Yes _____
Have you tried to cut down in the past? No Yes _____
Coffee/Cola: No Yes _____
Exercise: No Yes _____
Dental: Date of last exam: _____ Any problems? _____
Vision: Date of last exam: _____ Any problems? _____

NUTRITION

How many servings of fruits and vegetables do you eat each day? _____ per day
Do you drink milk or eat yogurt? No Yes If yes, how many servings per day? _____ per day

Have you had significant problems with any of the following? (Please circle those that apply)

- | | | | |
|---------------------------|-------------------------|------------------|----------------------|
| Weight loss/gain | Fevers, chills, sweats | Stroke | Anemia |
| Dizziness | Headaches | Trouble sleeping | Skin or hair changes |
| Tooth/gum problems | Depression | Anxiety | Loss of energy |
| Personal problems | Shortness of breath | Glaucoma | Cataracts |
| Coughing up blood | Problems swallowing | Pneumonia | Cough |
| Ankle swelling | Waking up out of breath | Hoarseness | Chest pain |
| Liver disease | Blood clot to lung/leg | Palpitations | Allergies |
| Heartburn/ulcer | Nausea or vomiting | Diarrhea | Gallbladder |
| Change in bowels | Blood in stool or urine | Constipation | Seizures |
| Difficulty with urination | Urinary tract infection | Black stools | Arthritis |
| Painful urination | Kidney disease/stone | Weakness | Vision loss |
| Painful joints | Double vision | Blurred vision | Heart murmur |

Is there anything else? _____

Thank you for taking the time to fill out this information.