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New Patient History Form For Men

Please answer these questions to the best of your ability. The information provided will help Dr. White take better care of you. This information is confidential and will not be released without your consent.

Name _____ Date _____ Birth Date _____
 Age _____ Occupation _____ Marital Status _____

What is the reason for your visit? _____

Circle any of the following you have had and enter the approximate date or age:

High Blood Pressure _____ Heart Disease _____
 Diabetes _____ High Cholesterol/Triglycerides _____
 Lung Disease _____ Kidney Disease _____
 Jaundice _____ Pneumonia/Asthma _____
 Tuberculosis _____ Chicken pox infection or vaccine _____
 Thyroid Disease _____ Orthopedic Problems _____
 Depression _____ Anxiety _____
 Glaucoma _____ Macular Degeneration _____
 Cancer _____ Skin Cancer _____
 Other Medical Problems: _____

Are you allergic to any medications? Please list them along with the reaction you had:

List all medications (including over the counter and herbal remedies): _____

List any serious injuries: _____

List any surgeries or hospitalizations. Please give year or approx. date and treating MD:

Indicate whether you have had any of the following procedures and the approximate year.

Cardiac Stress _____ Colonoscopy _____

Immunizations are an important part of your total health picture.

What have you had and when? Tetanus _____ Pneumovax _____ Flu _____

Hepatitis B (this is a 3 shot series) _____ MMR booster _____ Shingles _____

Family History

(Remember this is about your family not you.)

Year of Birth	Medical Conditions	Age of Death	Cause of Death
Mother _____			
Father _____			
Brother _____			
Brother _____			
Sister _____			
Sister _____			

Indicate the medical conditions your blood kin have had (place relationship in blank):

High Blood Pressure _____	Heart Attack _____	Stroke _____
High Cholesterol _____	Diabetes _____	Stomach Ulcer _____
Depression _____	Nervous Breakdown _____	Alcoholism _____
Other Addictions _____	Arthritis _____	Asthma _____
Osteoporosis _____	Migraines _____	Tuberculosis _____
Colitis _____	Kidney Disease _____	Liver Disease _____
Leukemia _____	Sickle Cell Anemia _____	Bleeding Tendency _____
Breast Cancer _____	Ovarian Cancer _____	Colon Cancer _____
Testicular Cancer _____	Prostate Cancer _____	

Additional Comments: _____

Tobacco Use:

Yes No Do you use any type of tobacco products? If not, skip to alcohol section.
Yes No Do you dip or chew?
Yes No Have you ever smoked?
Yes No Do you smoke now? If "yes", how many packs per day? _____
Age you started smoking? _____ Are you interested in quitting? _____
If you've stopped, age you stopped? _____

Alcohol Use:

Yes No Do you ever have alcoholic beverages? If "no" go to next section.
Yes No Do you have more than 3 drinks per week?
Yes No Have you ever cut back on your alcohol consumption?

TELL US ABOUT YOURSELF!

Education: (last high school grade completed, GED, College, post graduate)

List all the people who live at home with you (list name, relationship to you & year of birth)

Hobbies: _____

SAFETY:

- Yes No Do you wear seat belts?
- Yes No Are there handguns in your home?
- Yes No Do you keep handguns locked and away from kids?

Exercise:

- Yes No Do you exercise?
- Yes No Do you exercise at least 30 minutes three times a week?

Place a CHECK by any of the listed symptoms that **currently** apply to you:

Skin, Hair & Nails

- ___ Color Changes
- ___ Itching
- ___ Moles
- ___ Infections
- ___ Rash
- ___ Hair/Nail Change

Constitutional

- ___ Weakness
- ___ Fatigue
- ___ Fever
- ___ Chills
- ___ Night Sweats
- ___ Change in Appetite

Breast

- ___ Lumps
- ___ Pain
- ___ Discharge

Eyes

- ___ Vision Changes
- ___ Pain/Infection
- ___ Wear Glasses/Contacts
- ___ Date of last eye exam

Ears

- ___ Pain
- ___ Discharge
- ___ Hearing Loss
- ___ History of infections

Teeth

- ___ Problems
- ___ regular Dental care
- ___ Floss daily
- ___ Brush twice a day

Blood

- ___ Anemia
- ___ Easy Bruising
- ___ Enlarged Glands
- ___ Excessive Bleeding
- ___ Blood Transfusion
- ___ Year of transfusion

Endocrine

- ___ Goiter
- ___ Heat intolerance
- ___ Cold intolerance
- ___ Palpitations
- ___ Change in voice
- ___ Frequent urination
- ___ Excessive Thirst
- ___ Overeating
- ___ Weight Gain
- ___ Weight Loss
- ___ Abnormal Hair Growth
- ___ Low Testosterone Levels

Respiratory

- ___ Cough
- ___ Sputum
- ___ Shortness of breath
- ___ Wheezing
- ___ Pleurisy
- ___ Asthma
- ___ Spitting up Blood
- ___ Seasonal Allergy
- ___ last chest x-ray
- ___ Inhaler use?
- ___ Date of skin TB test

Musculoskeletal

- Joint Pain
- Joint Heat
- Joint Redness
- Joint Stiffness
- Joint Injury
- Bone difficulty
- Muscle Spasm
- Muscle Tenderness
- Morning Stiffness
- Height Loss
- Osteoporosis
- Spine Problems

Cardiovascular

- Chest Pain
- Shortness of breath lying down?
- How many pillows for sleep?
- Palpitations
- High Blood Pressure
- History of Rheumatic Fever
- Calves hurt when walking
- Fingers or toes hurt when cold
- Antibiotics must be used prior to dental work
- Shortness of breath on exertion?
- Shortness of breath at night
- Swelling of Feet
- Fainting Spells
- Heart murmur
- Varicose Veins
- Mitral Valve Prolapse
- Was MVP confirmed by an echocardiogram? (ultrasound of the heart)

Gastrointestinal

- Appetite Change
- Nausea
- Vomiting
- Difficulty Swallowing
- Indigestion
- Excessive Gas
- Vomiting Blood
- Abdominal Pain
- Jaundice
- Use of Antacids
- Diarrhea
- Constipation
- Blood in Stool/Toilet Tissue
- Hemorrhoids
- Hernia
- Use of Laxatives
- Frequent bowel movements
- Change in bowel habits

Depression

- Crying Spells
- Nervousness
- Anxiety
- Nightmares
- Insomnia
- Feelings of guilt
- Poor Self Esteem

Nervous System

- Convulsions/Seizure
- Faintness
- Incontinence
- Stroke
- Speech Difficulty
- Dizziness
- Tremor
- Trouble Walking
- Change in Sensation
- Transient Blind Spells
- Loss of Coordination
- Numbness
- Tingling
- Trouble rising from chair
- Migraines
- Other types of headaches
- Carpal Tunnel Syndrome
- Tennis Elbow

Urinary Tract

- Frequent infections
- Small urinary stream
- Can't hold urine
- Backache
- Pain w/urination
- Kidney Stones
- Blood in Urine
- Frequency

MEN'S ISSUES:**INFECTIONS:**

It's OK if you would rather talk with Dr. White about these sensitive issues and not answer these questions in writing.

- Have you ever had a sexually transmitted disease? YES NO
- | | | | | | | |
|------------|-----------|-----|----|-----------------------|-------|----|
| Which one? | Chlamydia | YES | NO | Human Papilloma Virus | YES | NO |
| | Herpes | YES | NO | Genital Warts | YES | NO |
| | Gonorrhea | YES | NO | Any other infections? | _____ | |

TESTICLES:

- YES NO Monthly self exam
- YES NO Pain in testicles
- YES NO Testicular masses

MISCELLANEOUS:

- YES NO PSA test? When _____
- YES NO Erection problems
- YES NO Sexuality issues/concerns
- YES NO Prostate enlargement
- YES NO Prostate Infections

The Relationship Chart:

During the past 4 weeks, how often have problems in your household led to:

Insulting or swearing? Yelling? Threatening? Hitting or Pushing

None of the time	A little of the time	Some of the time	Most of the time	All of the time
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Patient Signature _____ Date _____

Reviewed by _____ **Date** _____