MALE MEDICAL HISTORY FORM ALL INFORMATION IS CONFIDENTIAL

Name:_____ Birthdate _____/_____/_____
Last First Middle

Date:_____ RU Student ID #: _____

I HAVE OR HAVE HAD:	NO	YES	NOW
1. Any surgery			
2. Are you allergic to any medications? List Type:			
3. Heart disease			
4. Epilepsy (seizures)			
5. Asthma or lung disease			
6. Mono			
7. Cancer: Type			
8. Diabetes			
9. Thyroid problems			
10. Hypertension (high blood pressure)			
11. Liver disease, hepatitis or recent jaundice			
12. Severe Headaches			
13. Concussion			
14. A skin disorder			
15. Emotional problems/depression			
16. ADD/ADHD			
17. Urinary problems			
18. Anemia or Sickle Cell Anemia (disease or trait)			
19. Sexually Transmitted Infections (gonorrhea, syphilis, herpes, chlamydia, warts)			
20. Birth defects			
19. Elevated cholesterol			
20. Do you have an risk factors for HIV? for example: multiple partners, IV drug use, unprotected sex			
21. Injury of genitalia (includes hernia)			
22. Prostate problems/hydrocele/varicoele			
23. Bowel/stomach/rectal problems			
24. Discharge from penis, painful or bloody ejaculation			
25. Any sexual problems			
26. Do you drink and drive?			
27. Do you wear seat belts?			
28. Do you use bicycle or motorcycle helmets?			

FAMILY HISTORY: I have parents, brothers and/or sisters with: (check the disease and list the relative with the problem, (living or deceased) ☐Are you adopted

☐Diabetes_____ ☐High Cholesterol_____

☐Heart Attack_____ ☐Stroke_____

☐High Blood Pressure_____ ☐Cancer: type_____ _____

I have reviewed the above information with the patient. _____
Health Care Provider's Signature

Your medical records will be retained for 10 years after your last visit.
After that time they will be destroyed.

RUSHS – revised 07/15

RUSH **PATIE**

EMPI_____