Carroll County Health Department
Reproductive Health Services
Male Health History Form

Thank you for choosing the Carroll County Health Department for your healthcare needs. We are looking forward to seeing you for your appointment on _____ (date). So that we can make your appointment as efficient as possible, we are asking you to complete the health history form below. If there are any questions you do not understand or prefer not to answer, you may leave them blank. Please know that all your information will be kept confidential. When you are done, save the form and email it back to cchd.reprohealth@maryland.gov. If you have any questions, please contact us at 410-876-4930

First and Last Name: _____

Date of Birth: _____ Date you completed this form: _____

What is the reason for your visit?

_____

Current Medications and Allergies

Name of medicine, strength or dose, how often you take it, what you take it for:

_____

Are you allergic to any medications? NO ☐ YES ☐
If yes, what are you allergic to and what happens?

_____

Are you allergic to LATEX? NO ☐ YES ☐

Are you allergic to anything else? NO ☐ YES ☐

If yes, what are you allergic to and what happens?

Personal Medical History

Have you ever been diagnosed with any physical or mental health conditions? Please list below with the approximate year you were first diagnosed.

Any prior surgeries?

Have you ever been hospitalized for anything?

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Family History

Does anyone in your family have any health issues such as high blood pressure, heart disease, stroke, blood clots, cancer, or any other conditions for which they take medication?

Mother - NO ☐ YES ☐ If yes, please list:

Father - NO ☐ YES ☐ If yes, please list:

Siblings – NO ☐YES ☐ If yes, please list:

Children - NO ☐ YES ☐ If yes, please list:

Social History

Do you use nicotine or tobacco products? YES ☐ NO ☐ I quit _____ (date)

How often do you use nicotine or tobacco products? _____ Times a: day ☐ week☐ month ☐

Which of the following do you use (check all that apply)?
Cigarettes ☐ E-cigarettes/Vape ☐ Snuff ☐ Chew ☐
Cigars ☐ Pipe ☐ Other ☐

Do you use cannabis/pot/marijuana, CBD, or THC products in any form?

YES ☐ NO ☐ I quit _____ (date)

How often do you use cannabis, CBD, or THC products? _____
Times a: day ☐ week☐ month ☐

Do you drink alcohol in any form? YES ☐ NO ☐ I quit _____ (date)

How many drinks do you usually have at one time? _____

How often do you drink alcohol? _____ Times a: day ☐ week☐ month ☐

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Do you drink caffeine in any form? YES ☐ NO ☐ I quit _____ (date)

How many servings of caffeine do you have a day? _____

Which of the following do you use (check all that apply)?
Coffee ☐ Tea ☐ Energy Drinks ☐ Pills/drops/supplements ☐ Other ☐

Do you use any other drugs or substances? YES ☐ NO ☐ I quit _____ (date)

How often do you use other drugs or substances? _____ Times a: day ☐ week☐ month ☐

Which of the following do you use (check all that apply)?
Opiates/Heroin ☐ Cocaine/Crack ☐ Anxiety pills/Benzodiazepines (Benzos, BZDs) ☐
Amphetamines/Speed ☐ PCP/LSD/Ecstasy/Hallucinogens ☐ Inhalants/Huffing ☐

Any drugs other than prescribed: _____ (list)

Are you regularly around someone else who uses alcohol, nicotine, cannabis, or any other street drugs?
NO ☐ YES ☐

Do you exercise? NO ☐ YES ☐
If yes, how often? Daily ☐ Weekly ☐ Monthly ☐

[PHQ-2]
Over the last 2 weeks, have you had little interest or pleasure in doing things? NO ☐ YES ☐
Over the last 2 weeks, have you felt down, depressed, or hopeless? NO ☐ YES ☐

Adolescent Confidentiality Assessment (for patients under 18 years old)

Are your parents/guardian aware that you are coming here for services? NO ☐ YES ☐

May we share health and billing information with them? NO ☐ YES ☐

If you have any concerns about your parent/guarding being aware of your visit or involved in your health care, please explain:

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Safety Screening

Do you ever feel afraid of your partner or someone in your life? NO ☐ YES ☐

Have you ever run away due to violence in the home? NO ☐ YES ☐

Have you ever exchanged sex for food, a place to stay, or drugs? NO ☐ YES ☐

Has anyone ever threatened, hurt, or intimidated you? NO ☐ YES ☐

If yes, when?

Does you sex partner ever refuse to use birth control or wear a condom? NO ☐ YES ☐

Are you feeling pressured to have sex? NO ☐ YES ☐

Do you have thoughts of harming yourself for others? NO ☐ YES ☐

If yes, when was the last time?

Do you have any friends that use drugs? NO ☐ YES ☐

Sexual and Contraceptive History

How old were you the first time you had sexual intercourse?

Have you had a new sexual partner in the last 6 months? NO ☐ YES ☐

If yes, how many new partners in the last 6 months?

Do you have sex with men, women, or both?

How many sexual partners you have had in your lifetime?

How often do you use condoms, from 0% (none of the time) to 100% (all of the time)?

What type of sex do you have (check all that apply)? Oral ☐ Vaginal ☐ Anal/Rectal ☐

Have you ever been tested for sexually transmitted infections or HIV? NO ☐ YES ☐

If yes, when was the last time?

Have you ever had a sexually transmitted infection before? NO ☐ YES ☐
If yes, what kind of infection (CHECK all that apply)?
Chlamydia ☐ Gonorrhea ☐ Herpes (HSV) ☐ HPV (warts) HIV ☐
Trichomoniasis (Trich) ☐ Syphilis ☐

History of Hepatitis B or C infection? NO ☐ YES ☐

If yes, what type of infection and when were your diagnosed?

Have you ever had a blood transfusion before 1984? NO ☐ YES ☐

Would you like to have HIV testing on the day of your appointment? NO ☐ YES ☐

If you answered YES to any of the above questions, please explain or provide more information:

Parenting History

Have you fathered any children before? NO ☐ YES ☐

If yes, how many?

If yes, how old is your youngest child?

Do you or your partner plan on getting pregnant in the next 12 months? NO ☐ YES ☐

Partner Assessment

Does your **partner** have sex with men, women, or both?

Are you and your partner in a monogamous or exclusive relationship? NO ☐ YES ☐

Does your partner have a history of any sexually transmitted infections? NO ☐ YES ☐

If yes, what kind of infection (check all that apply)
Chlamydia ☐ Gonorrhea ☐ Herpes (HSV) ☐ HPV (warts) ☐
HIV ☐ Trichomoniasis (Trich) ☐ Syphilis ☐

Does your partner exchange sex for drugs or money? NO ☐ YES ☐

Does your partner inject or use IV drugs? NO ☐ YES ☐

Has your partner been in jail, prison, or a detention center? NO ☐ YES ☐

If you answered YES to any of the above questions, please explain or provide more information:

Contraceptive History

Does your partner use any of the following contraceptive options:
Depo Provera (injection)? NO ☐ YES ☐
Oral contraceptive pills? NO ☐ YES ☐
Patch? NO ☐ YES ☐
Vaginal ring? NO ☐ YES ☐
IUD? NO ☐ YES ☐
Arm implant? NO ☐ YES ☐
Condoms? NO ☐ YES ☐
Other: NO ☐ YES ☐

What was the most recent type of contraception you or your partner used?

Any problems with any of the methods used before?

Symptom Checklist

Are you experiencing any of the following:

Discharge/drainage from your penis or rectum? NO ☐ YES ☐

Pain? NO ☐ YES ☐

Pain or burning with urinating or ejaculation? NO ☐ YES ☐

Sore, ulcer, lesion? NO ☐ YES ☐

Itching? NO ☐ YES ☐

Rash? NO☐ YES ☐

Irritation? NO ☐ YES ☐

If you answered YES to any of the above questions, please explain or provide more information: