PURCHASE COLLEGE STUDENT HEALTH SERVICE
MEN'S HEALTH

Date: _____

Name: _____ **DOB:** ___/___/___ **Age:** _____

THIS FORM IS PRIVATE AND CONFIDENTIAL (please fill out front and back of this page)

What is the reason for your visit today? _____

Have you ever had sexual relations? N___ Y___ (if yes) with: women___ men___ both___

Are you currently in a sexual relationship? N___ Y___ (if yes) with: women___ men___ both___

With how many people are you currently having sex? _____

Total number of sexual partners past and present? _____

Do you use condoms during vaginal/anal sex? always____ sometimes ___ never ___

Do you use condoms during oral sex? always____ sometimes___ never ___

If you have a male partner, does he use condoms? always ___ sometimes ___ never___

Have you ever performed oral sex? N ___ Y ___ (if yes) on: women ___ men ___ both ___

Do you take the semen (cum) into your mouth? ___ Y ___ N

Have you ever had oral sex performed on you? N ___ Y ___ (if yes) by: women ___ men ___ both ___

Have you ever had receptive anal intercourse? N ___ Y ___
(Had a man's penis in your rectum)

Have you ever had insertive anal intercourse? N ___ Y ___
(Put your penis in a man's or woman's rectum)

Have you ever been forced into a sexual act? N ___ Y ___ _____

_____

UROGENITAL REVIEW OF SYMPTOMS (How long have you had this?)

Penis:

___ sores ___ bumps _____

___ warts ___ rash _____

___ itching ___ pain _____

___ discharge (if yes): ___ white___ blood ___ clear _____

___ pain or burning on urination? _____

___ blood in urine? _____

___ deep yellow or brown color to urine? _____

___ frequent urination? _____

___ pain on ejaculation? _____

Rectum or Anus:

___ sores ___ bumps _____
___ warts ___ rash _____
___ itching ___ pain _____
___ discharge (if yes): ___ pus ___ blood ___ clear _____
___ pain in rectum on ejaculation? _____
___ pain in rectum during bowel movement? _____
___ pain in rectum during sexual intercourse? _____

Name:_____ CID:_____ Date: _____

Pubic Area or Groin:
___ sores ___ bumps _____
___ warts ___ rash _____
___ itching ___ pain _____
___ swollen glands N ___ Y ___ (if yes) where? _____ Are they painful? N ___ Y ___

Testicles and Scrotum:
___ swelling _____
___ lumps or bumps _____
___ pain _____
___ itching _____
___ redness _____

Throat/Mouth: ___ burns/sores/blisters on lips/mouth _____
___ sore throat _____
___ difficulty swallowing _____
___ painful and/or swollen neck glands _____

Eyes:
___ painful
___ itchy
___ discharge ___ pus ___ crusty

UROGENITAL HISTORY

please explain what happened and when

Have you ever had an injury to your testicles or scrotum? N ___ Y ___ _____

Do you do monthly testicular self-exams for testicular cancer? N ___ Y ___

Have you ever had a hernia? N ___ Y ___
If yes, where was it? _____
Was it repaired surgically? _____

Have you ever had an STI (sexually transmitted infection)? N ___ Y ___
(also known as STD)
If yes, which one(s)? Chlamydia ___ Gonorrhea ___ Syphilis ___ Epididymitis ___ Herpes ___
Genital Warts ___ Molluscum ___ HIV ___ other ___

Were you ever given antibiotics or other medications for an STI? N ___ Y ___

If yes, do you remember the name of the medication? _____

Was your partner treated? N ___ Y ___

Does your current sexual partner have symptoms or a diagnosis of an STI? N ___ Y ___
If yes, has she/he received treatment for it? N ___ Y ___

Have you ever used a needle to inject drugs? N ___ Y ___
If yes, were the needles clean? Always ___ Sometimes ___ Never ___

Have you ever had a tattoo or a piercing? N ___ Y ___
If yes, was the equipment used clean (sterilized)? N ___ Y ___ Don't know ___

Have you had Hepatitis B Immunization? N ___ Y ___

Have you had Hepatitis A Immunization? N ___ Y ___

Have you ever been tested for HIV? N ___ Y ___ (if yes): (+) ____ (-) ___ Date_____

HCP Reviewed: _____ Date: _____ Patient's Signature: _____