1. Last Name		First Name						MI	
2. Patient Number									
3. Date of Birth (MM/DD/YYYY)									
	Month		Day		Year				
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White									
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported									
6. Gender ☐ Female ☐ Male									
7. County of Residence									
8. Home Address:					9. Marital Status:				

CONFIDENTIAL

North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

MALE REPRODUCTIVE HEALTH HISTORY

Date: _____

A. GENERAL INFORMATION (Please complete the following)

1. May we contact you by mail? ☐ Yes ☐ No By phone? ☐ Yes ☐ No Your phone number is _____
2. Do you have a primary care provider? ☐ Yes ☐ No If yes, who? _____

   If No a referral to a primary care provider is offered ☐ Yes ☐ No
3. Special Needs/Primary Language _____
4. Highest grade completed in school _____

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: _____
2. Medications: Do you take any medications (prescription or over the counter), diet or herbal supplements? ☐ Yes ☐ No If yes, what? _____
3. Self and Family Medical History: Put an **X** under **SELF** and/or **X** under **FAMILY** (parent, grandparent, brother, sister or your child)

SELF	FAMILY		SELF	FAMILY	
☐	☐	1. Heart disease/vascular problems (blood clots)	☐	☐	6. Liver Disease
☐	☐	2. Sickle Cell Disease or Trait/Blood Disorder	☐	☐	7. Migraine Headache (with aura)
☐	☐	3. Diabetes	☐	☐	8. Cancer
☐	☐	4. High Blood Pressure /High cholesterol	☐	☐	9. Mental Illness/Emotional Disorders
☐	☐	5. Lung Disease	☐	☐	10. Other
If yes to any of the above, please explain:					

C. SOCIAL/ENVIRONMENTAL HISTORY

1. Do you currently use tobacco, including cigarettes, smokeless tobacco, electronic devices, or other products?

   ☐ Yes ☐ No If yes, what type? _____ How long? _____
2. Drink alcohol? ☐ Yes ☐ No If yes, how much? _____ How long? _____
3. Use recreational drugs? ☐ Yes ☐ No If yes, what type? _____ How often? _____
4. Are you regularly around someone else who uses alcohol, tobacco, electronic nicotine devices or recreational drugs?

   ☐ Yes ☐ No If yes, what do they use? _____ How often? _____

D. IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES (UTD = up-to-date; REF = referred, and NA = not applicable)

Td/Tdap ☐ UTD ☐ REF ☐ NA	MMR ☐ UTD ☐ REF ☐ NA	Varicella ☐ UTD ☐ REF ☐ NA	HPV ☐ UTD ☐ REF ☐ NA	Hepatitis A ☐ UTD ☐ REF ☐ NA
Hepatitis B ☐ UTD ☐ REF ☐ NA	Meningococcal ☐ UTD ☐ REF ☐ NA	Pneumonia ☐ UTD ☐ REF ☐ NA	Influenza ☐ UTD ☐ REF ☐ NA	

Source of Information: ☐ NCIR ☐ Patient ☐ Other Written Documentation

Interviewer's Signature: _____ Date: _____

Signature of Interpreter (if used): _____ Date: _____