CONFIDENTIAL

North Carolina Department of Health and Human Services
Division of Public Health
Reproductive Health Section

Place Patient Label Here

BIOLOGICAL MALE REPRODUCTIVE HEALTH HISTORY

Date: _____

A. GENERAL INFORMATION

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. Hearing, visual, language and/or physical accommodation needs/Primary Language(s) _____
4. Highest grade completed in school _____

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: _____
2. Medications: Do you currently 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)	☐	☐	7. Liver Disease
☐	☐	2. Sickle Cell Disease or Trait/Blood Disorder	☐	☐	8. Migraine Headache (with aura)
☐	☐	3. Diabetes	☐	☐	9. Cancer
☐	☐	4. High Blood Pressure /High cholesterol	☐	☐	10. Mental Illness/Emotional Disorders
☐	☐	5. Lung Disease	☐	☐	11. Other
☐	☐	6. Infertility			
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: _____