

New Patient Male History Form

Troutman Family Medicine

Patient Name: _____ **DOB :** _____ **Date:** _____

Referred by: Bellsouth; Yellow pages; Yellow book; Alltel Phonebook; Newspaper; Physician _____; Friend _____; Family _____ Other _____

Describe your main problem _____

Where is your problem located? _____
 How severe is your problem? _____
 How long have you had this problem? _____
 When does this problem occur? _____
 Where were you when this problem started? _____
 What other things happen with this problem? _____
 What makes this problem worse or better? _____

List previous hospitalizations/Surgeries/Serious Injuries _____ **When?** _____

Patient Social History

Marital Status: Single Married Separated Divorced Widowed
 Use of alcohol: Never Rarely Moderate Daily _____
 Use of tobacco: Never Previously but quit Current packs per day _____
 Use of Drugs: Never Type/Frequency _____

Family Medical History

	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling's	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Have you ever had the following?

Diabetes.....	yes	no
Hypertension.....	yes	no
Asthma.....	yes	no
Thyroid trouble.....	yes	no
Cancer.....	yes	no
Stroke.....	yes	no
Heart trouble.....	yes	no
Arthritis/gout.....	yes	no
Convulsions.....	yes	no
Bleeding tendency.....	yes	no
Skin Cancer.....	yes	no
Venereal disease.....	yes	no
Hereditary defects.....	yes	no
Cholesterol.....	yes	no

ALLERGY:

Penicillin or other antibiotics	No	Yes
Morphine, or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Iodine or other antiseptic...	No	Yes
Other drugs/medications		
Known food allergies		

List Medications you are currently taking

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Prevention- Male	Date:
Complete Physical Examination	
Prostate Cancer Screening	
Bone Density for osteoporosis	
Cholesterol/ Lipid Blood test	
Colonoscopy	
Skin Cancer Screening	
Flu Vaccine	
Pneumovax	
Tetanus	

Cosmetic & Dermatology	Yes	No
Do you use tanning beds?		
Any history of skin cancer		
Are you interested in following:	Yes	No
Laser Hair Removal		
Skin Peels		
Facial rejuvenation		
Botox®; Dysport®		
Laser Vein Removal		
Fillers		
Skin Tightening		

Patient Signature: _____