OMAHA OB/GYN ASSOCIATES, P.C.

119 North 51st St. Suite 200 / (402) 932-8020
16909 Lakeside Hills Ct. Suite 201 / (402) 991-1900
Emergencies & After Hours / (402) 932-8020
Medical Record Fax / (402) 905-3041
Office Fax / (402) 905-3042

MALE MEDICAL HISTORY *(Please Complete Before Your Visit)*

Contact Information

Name: _____ Preferred First Name (if different): _____

Phone #: _____ *(cell # may be preferred)* OK to leave a message? _____YES _____NO

Referred by: _____ Preferred Pharmacy: _____

Other Health Care Providers (**CHECK** if you would like a note sent to your health care provider)

____Primary Doctor: _____ ____Counselor/Therapist: _____

____Psychiatrist: _____ ____Other: _____

Demographic Information

Are you (circle all that apply):

Single Married Widowed Committed Relationship Same Sex Relationship

Education:

Less than 12 years High school graduate Currently in school

College Degree Postgraduate degree

What is your profession/what type of work are you doing? _____

Information About Your Condition

What are your primary concerns? _____

_____

How long have you had the issues or concerns? _____

Is there an event associated with the onset of symptoms? ___No ___Yes (explain) _____

_____

What medical/nonmedical treatments have you tried? _____

_____

Medical History

✔**CHECK** all that apply:

____Fatigue	____Frequent urination	____Headaches
____Weight gain	____Frequent urination at night	____Difficulty focusing
____Difficulty sleeping	____Frequent UTIs	____Irritability
____High blood pressure	____Leakage of urine	____Anxiety
____High cholesterol	____Enlarged prostate	____Depression
____Blood clot	____Elevated PSA level	____Bipolar Disorder
____Heart Attack	____Prostate infection	
_____Stroke	____Prostate cancer	____Lack of sexual desire
		____Premature ejaculation
____Constipation	____Diabetes	____Delayed ejaculation
____Diarrhea	____Hypothyroid	____Decreased hardness of erection
	____Back pain	____Difficulty achieving an erection

Other medical conditions or history of cancer: _____

_____

Have you used any of the following medications/treatments?

Medication	**Effective?** (Yes or No)	**Unwanted Side Effects or Additional Comments:**
____Viagra		
____Levitra		
____Cialis		
____Testosterone gel/cream		
____Testosterone pellet		
____Other: _____		

**How often do you exercise?* Rarely 1-2 Times weekly 3-5 times weekly Daily

**How many cups of caffeine per day?* (include coffee, tea, soda) 0 1-3 4-6 More than 6

**Do you smoke?* NO YES *How many cigarettes per day?* _____ *For how many years?* _____

**How often do you drink alcohol?* Never Rarely Monthly Weekly Daily

**Do you use recreational drugs?* NO YES

**How would you describe your diet?*

Well- Balanced Fried/Fast food Low Cholesterol Low Fat Other: _____

**Please list any causes of stress* (ex. finances, work, relationship) _____

**How many children do you have?* _____ *Age of children?* _____

**Have you ever been the victim of:* Verbal abuse Physical abuse Sexual abuse Rape No Answer

ALLERGIES: _____

Current Medications

Medication	Dose/Frequency	

Surgical Procedures

Year	Procedure	Year	Procedure

Family History

✔Check if you were you adopted _____ (Leave BLANK If you do not know your family history).

✔Check box if a family member has been diagnosed/treated for any of the following:

	Mom	Dad	Brother	Sister	Grandma (mom's parent)	Grandma (dad's parent)	Grandpa (mom's parent)	Grandpa (dad's parent)
Anxiety								
Depression								
Heart Disease								
High Cholesterol								
Stroke								
Breast cancer								
Ovarian cancer								
Prostate cancer								
Uterine cancer								

Additional comments or conditions not listed above: _____

_____