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_____

Excessive exposure at home or work to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Noise

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
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: _____