

Name _____ Age _____ Class _____ Today's Date _____

NOTE: Please attempt to answer all the questions that are applicable to you on this form. Although responses may be very personal to you, this information is important for us to provide you with appropriate health care. This form is confidential and is not available to anyone outside the Rutgers University Health Services without your written permission. This form will be reviewed by your health care practitioner during your visit. If you should feel uncomfortable answering any questions before discussing them with your practitioner, please feel free to leave them blank.

Reason for visit: Infection Contraceptive advice Other _____

YOUR PAST MEDICAL HISTORY

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| YES | NO | NOW | Have you ever had or been exposed to: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumps or pain in testicles |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Undescended tests |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Warts |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV (AIDS Virus) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal penile discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine or semen |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain on urination |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Burning on urination |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequency of urination |

Have you ever had a problem requiring a visit to a urologist?

Did your mother take DES or any hormones when she was pregnant with you? Yes No Don't Know

Do you use any of the following?

- | | | |
|--------------------------|--------------------------|--------------------|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cigarettes |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol |
| <input type="checkbox"/> | <input type="checkbox"/> | Recreational drugs |
| <input type="checkbox"/> | <input type="checkbox"/> | IV drugs |

Is there anyone in your life that you are afraid of? **YES** **NO**

HOSPITALIZATION - SURGERY

Date	Diagnosis/Treatment
_____	_____
_____	_____

Did you receive blood or blood products between 1977-85?
Yes Specify: _____ No

RETURN TO:

- Busch/Livingston Health Center !110 Hospital Rd., Piscataway, NJ 08854-8043 ! 732-445-3250 ! FAX: 732-445-3725
- Camden Health Center ! 326 Penn St., Camden, NJ 08102 ! 856-225-6005 ! FAX: 856-225-6186
- Hurtado Health Center ! 11 Bishop Pl., New Brunswick, NJ 08901-1180 ! 732-932-7402 ! FAX: 732-932-8255
- Newark Health Center ! 249 University Ave., Room 104, Newark, NJ 07102 ! 973-353-5231 ! FAX: 973-353-1390
- Willets Health Center ! 11 Suydam St., New Brunswick, NJ 08901-2889 ! 732-932-9805 ! FAX: 732-932-1465

YOUR SEXUAL HISTORY

Have you ever been sexually involved with another person?
Yes No
If yes, age at first encounter _____
If yes, your partners are or have been
Female Male Both
Number of life time sexual partners _____
Do you have questions, or wish to discuss sexual orientation, sexual expression, masturbation, rape, incest, sexual abuse or any issues of sexuality? Yes ____ No ____

Contraceptive History

Do you use condoms to prevent pregnancy?
Yes No N/A

Do you use condoms to prevent sexually transmitted diseases? Yes No N/A

Contraceptive methods used by you and your partner at present, and in the past:

DATES	METHOD	PROBLEMS
_____	_____	_____
_____	_____	_____

SELF CARE

Do you take daily medications or vitamins?
Yes Specify _____ No
Do you perform testicular self-examination monthly?
Yes No
Do you have questions or concerns specific to men's health?

Do you have any other questions? _____

FOR STAFF USE ONLY		
Clinical Review	Initials	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

In order to establish a reproductive health care history in your medical record, we are asking you to complete the form on the reverse side. As with all your medical records, this form will be retained in strict confidence by us. No access to this document by outside parties will be granted without your specific written consent.

For many issues related to health care, we have prepared information pamphlets and designed programs to aid you in learning about your body and yourself. Please feel free to ask us about any of these subjects.

Below are some commonly asked questions about this form:

I'm uncomfortable with some of the questions. Do I have to answer all of them?

No, if you are uncomfortable with a question and feel reluctant to answer it, you may leave it blank and discuss it with your practitioner.

Why is it necessary to know the age at which I first had sex?

Age at first sexual contact can indicate someone who may be at greater risk for infections and sexually transmitted diseases. Additionally, some men may have experienced unwanted sexual advances earlier in their lives and they may wish to discuss them at this time.

I'm uncomfortable with the question about masturbation, incest, rape and other issues. What is this all about?

Our intention in asking this question is to provide you with an opportunity to discuss any one of these sensitive issues with a medical professional. These issues can directly affect your present and future sexual expression and relationships.

What is DES and what does it have to do with my health?

DES stands for diethylstilbestrol, which is a synthetic estrogen given to some pregnant women between 1940 and the late 1960's in order to prevent miscarriage. It has been found that this medication may put the children of women who took DES at risk for certain medical conditions.

What do alcohol and drugs have to do with sex?

Alcohol and other drugs may be associated with difficulties in sexual performance or may cloud your judgement, and may lead to behaviors that put you at risk for STD's.

Why do I need to be concerned about contraception?

If you have sex with women at any time, you need to be concerned with contraception (birth control). The decision to contracept (and which method to use) is ideally discussed with your partner prior to sexual contact. In addition to other methods of contraception, the proper use of a condom during sexual intercourse is necessary to prevent the spread of sexually transmitted diseases, including AIDS.