

FRED GROSSMAN M.D.
The Male Care Center

4200 W. Conejos Place, Denver, CO 80204

MEDICAL HISTORY FORM

Please print and complete fully

NAME: _____ DATE _____

BRIEFLY DESCRIBE THE REASON FOR THIS VISIT: _____

HAVE YOU HAD ANY OF THE FOLLOWING: (if YES, please explain)

NERVOUS DISORDER or STROKE Yes No _____

HIGH BLOOD PRESSURE Yes No _____

HEART DISEASE Yes No _____

BREATHING TROUBLE Yes No _____

INTESTINAL TROUBLE Yes No _____

URINATION OR KIDNEY PROBLEM Yes No _____

BONE, JOINT, OR BACK PROBLEM Yes No _____

FEMALE DISORDER Yes No _____

CIRCULATION DEFICIENCY Yes No _____

JAUNDICE or LIVER DISEASE Yes No _____

ANEMIA or BLOOD DISEASE Yes No _____

DIABETES or OTHER GLAND DISEASE Yes No _____

CANCER Yes No _____

DO YOU PARTICIPATE IN SPORTS, EXERCISE, OR DAILY WALKS? Yes No (If YES, how often?) _____

HAVE YOU EVER HAD MAJOR SURGERY? Yes No (If YES, to surgery, what type and when?) _____

HAVE YOU EVER HAD A VASECTOMY? Yes No

HAVE YOU EVER BEEN HOSPITALIZED OR TREATED FOR A MAJOR ILLNESS? Yes No (If YES, why & when?) _____

HAVE YOU EVER HAD AN ACCIDENT WITH MAJOR INJURY OR FRACTURES? Yes No (If YES, what type & when?) _____

(FEMALES ONLY) HOW MANY PREGNANCIES HAVE YOU HAD? _____ LIVE BIRTHS? _____

MISCARRIAGES OR ABORTIONS? _____

*****PLEASE CONTINUE ON OTHER SIDE*****

MEDICAL HISTORY FORM – Pg. 2

LIST ALL MEDICATIONS YOU TAKE (include vitamins, birth control pills, aspirin, health food, etc.):

Medication	Dose (mg)	How Often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU HAVE ANY ALLERGIES? Yes No (If YES, to what and what is your reaction?) _____

DO YOU USE TOBACCO? Yes No DETAILS: Cigarettes (how many and for how long), cigars, pipe, chewing tobacco? _____

DO YOU USE ALCOHOL OTHER THAN SOCIALLY? Yes No (If YES, how much and what type?) _____

DO YOU HAVE ANY HISTORY OF ALCOHOLISM? Yes No DRUG ABUSE? Yes No

ARE YOU CURRENTLY MARRIED DIVORCED SEPARATED SINGLE, NEVER MARRIED (provide details)

OCCUPATION: (Past) _____

(Present) _____

FAMILY HISTORY:

	AGE	LIVING/DECEASED	STATE OF HEALTH
MOTHER	_____	_____/_____	_____
FATHER	_____	_____/_____	_____
BROTHER(S)	_____	_____/_____	_____
	_____	_____/_____	_____
SISTER(S)	_____	_____/_____	_____
	_____	_____/_____	_____
CHILDREN	_____	_____/_____	_____
	_____	_____/_____	_____
	_____	_____/_____	_____

WHAT ILLNESSES RUN IN YOUR FAMILY? (diabetes, kidney stones, cancer, bladder/kidney problems, etc.) _____

NOTES: (for office use only)