

Date ____/____/____

Male Initial History

ACAP Health Services
A Division of Aroostook County Action Program

Name _____ <small>Last First</small>	SS# _____
Mailing Address _____	Client# _____
Phone _____ <small>Home Work Cell</small>	Date of Birth ____/____/____ Age ____
Please check all the ways we can contact you: <input type="checkbox"/> by mail	Race <input type="checkbox"/> White <input type="checkbox"/> Black
<input type="checkbox"/> Home phone (best time _____) <input type="checkbox"/> Work phone (best time _____)	<input type="checkbox"/> Native American <input type="checkbox"/> Asian
<input type="checkbox"/> other _____ (best time _____) <input type="checkbox"/> okay to leave message.	<input type="checkbox"/> Hispanic <input type="checkbox"/> Other
<input type="checkbox"/> email _____	
If you are a teenager, do your parents know you are here? <input type="checkbox"/> Yes	
<input type="checkbox"/> No	

Emergency Contact Person _____	Relation _____
Address _____	Phone _____

Are you employed? Yes No Occupation _____ Employer _____

Are you a Student: Yes No School you attend _____ Years completed _____

Marital status: Single Married Living with partner

Do you have Health Insurance or MeCare(Medicaid)? Yes No Co. Name and ID _____

Weekly gross income (before taxes) including partner/spouse living with you \$ _____

How many persons are supported by this income? _____

Medical History

Hospitalizations or Surgeries _____ Do you smoke? Yes No, # per day _____

Other medical problems/conditions _____ Do you drink coffee/tea? Yes No ___ cups/day

Major illnesses/injuries _____ Do you drink soda? Yes No ___ # per day

Allergies (include allergies to medications) _____ Do you drink Alcohol? _____

Did your mother take DES to prevent miscarriage? Yes No How many drinks to you usually have? _____

Current medications (including over the counter and vitamins/herbal supplements) _____

Do you have, or have you ever had any of the following: _____ comments _____

Epilepsy/seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis A,B or C/Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Gall Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Birth Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Blood Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Name _____

Client # _____

Immunization History

Rubella/MMR Yes No Date ____/____/____ Tetanus Yes No Date ____/____/____

Tuberculosis (TB) Yes No Date ____/____/____ Hepatitis B Yes No Date ____/____/____

Hepatitis A Yes No Date ____/____/____ Do you know your blood type? Yes No Type _____

Family Medical History Have your parents, brothers/sisters or grandparents had any of the following:

Heart Attack or Stroke before age 60 Yes No _____

High Cholesterol Yes No _____

Diabetes Yes No _____

High Blood Pressure Yes No _____

Blood disorders/transfusion Yes No _____

Prostate or Testicular Cancer Yes No _____

Other _____

Mental Health History

Have you ever been sexually assaulted? Yes No

Have you ever been physically abused or hit? Yes No

Have you ever had mental health problems or depression? Yes No

Have you ever received counseling? Yes No

To the best of my knowledge, this information is complete and accurate.

If my insurance is to be billed for all or part of today's visit I authorize the release of any medical or other information needed to process the claim. I authorize payment of medical benefits to ACAP Health Services.

Please sign _____ Date ____/____/____

Statement of confidentiality

This medical record is confidential, and it will not be released to any person or organization outside of ACAP Health Services without your written consent, except as outlined in our Notice of Privacy Practices (may release information without your written consent for the purposes of treatment, payment or operations)

Nurse Practitioner _____ Date ____/____/____