California State University, Long Beach  
Student Health Services, Health Resource Center

Men’s Health Clinic Questionnaire
This questionnaire is distributed to all male students that are interested in receiving additional services through the Men’s Health Clinic. The completion of this questionnaire is vital in providing you the best possible services that would meet your health needs during your visit here at the Student Health Center. The information you provide is confidential and will not be released outside the Student Health Center without your written permission. Please take a few moments to answer the following questions to the best of your knowledge. Thank you.

Demographics

Ethnicity:
[ ] African-American/Black/African  [ ] Middle Eastern/Arabic/Persian  
[ ] Asian-American/Pacific Islander  [ ] Native American/Alaskan Native  
[ ] Caucasian/European-American/White  [ ] Other/Multiethnic_______________  
[ ] Hispanic/Latino/Chicano/Mexican-American

Classification:
[ ] Undergraduate  [ ] Graduate  
[ ] Freshman  
[ ] Sophomore  
[ ] Junior  
[ ] Senior

Housing:
[ ] On-campus housing  [ ] Off-campus housing

Confidential Questions:

1. Have you ever smoked cigarettes?  
[ ] Yes  [ ] No

If YES, please describe yourself as:  
[ ] Former smoker (have stopped for at least 30 days)  
[ ] Regular smoker (1-10 cigarettes per day)  
[ ] Heavy smoker (more than 10 cigarettes per day)  
[ ] Social smoker (smoke only at parties/gatherings) Are you interested in quitting smoking?  
[ ] Yes  [ ] No

2. Do you drink alcohol?  
[ ] Yes  [ ] No

If YES, How many drinks do you consume in an average week?  
[ ] 0-3 drinks per week  [ ] 21-25 drinks per week  
[ ] 4-6 drinks per week  [ ] 26-30 drinks per week  
[ ] 7-10 drinks per week  [ ] 31-35 drinks per week  
[ ] 11-15 drinks per week  [ ] 36-40 drinks per week  
[ ] 16-20 drinks per week  [ ] Over 40 drinks per week

Have you ever felt that you should cut down on your drinking?  
[ ] Yes  [ ] No

Please continue on back of this sheet. Thank you.
3. **Do you use recreational (non-prescription drugs)?**
   | Yes | No |
   __If YES, please indicate all the drugs you have used in the past 30 days:__
   | anabolic steroids | inhalants |
   | cocaine | marijuana |
   | ecstasy | stimulant |
   | hallucinogens | other drugs |

**Please indicate all the drugs you have used in the past (but are not currently using):**
   | anabolic steroids | inhalants |
   | cocaine | marijuana |
   | ecstasy | stimulants |
   | hallucinogens | other drugs |

**Do you have any concerns regarding your drug use?**
   | Yes | No |

4. **Please indicate your present level of physical activity (exercise):**
   | Never exercise |
   | Rarely exercise |
   | Inconsistently exercise |
   | Regularly exercise |

**How many times per week do you exercise?**
   | 1 | 6 | 11 |
   | 3 | 7 | 12 |
   | 4 | 9 | 13 |
   | 5 | 10 | 15 |

**Please indicate all the types of activities you engage in regularly:**
   | aerobics | play racquet sports |
   | dance | plays rugby |
   | hike | plays soccer |
   | campus athletic team | runs |
   | jog | swims |
   | lift weights | uses treadmill/stairmaster or elliptical trainer |
   | play basketball | walks vigorously |

5. **Do you have a special diet?**
   | Yes | No |

**If YES, please indicate:**

**Please describe your diet (indicate all that apply):**
   | 1 meal per day | unhealthy diet |
   | 2 meals per day | dietary supplements |
   | 3 meals per day | fast food frequently |
   | >3 meals per day | fruits and vegetables daily |
   | healthy diet | high protein diet |
   | vegetarian diet | low fat diet weigh |
   | loss diet | low cholesterol diet |
   | weight gain diet | diabetic diet |

**Do you have any concerns regarding you weight or appearance:**
   | Yes | No |

**Have you had your cholesterol level checked in the past 5 years?**
   | Yes | No |

**If YES, please indicate if the level was:**
   | Normal | Abnormal |

*Please continue on the next page. Thank you.*
6. Have you ever had severe sunburn?
   [ ] Yes  [ ] No

Do you regularly use sunscreen?
   [ ] Yes  [ ] No

Have you ever had an immediate family member (mother, father, or siblings) with an abnormal mole or skin cancer?
   [ ] Yes  [ ] No

How often do you brush your teeth?
   [ ] once daily  [ ] after every meal
   [ ] twice daily  [ ] rarely
   [ ] three times daily  [ ] never

How often do you floss your teeth?
   [ ] once daily  [ ] after every meal
   [ ] twice daily  [ ] rarely
   [ ] three times daily  [ ] never

How often do you wear a seat belt while driving or riding in a car?
   [ ] always  [ ] 50-75% of the time
   [ ] 90-100% of the time  [ ] less than 50% of the time
   [ ] 75-90% of the time  [ ] never

How often do you use a bicycle and/or motorcycle helmet?
   [ ] always  [ ] 50-75% of the time
   [ ] 90-100% of the time  [ ] less than 50% of the time
   [ ] 75-90% of the time  [ ] never

Have you ever been involved in a motor vehicle accident due to reckless and/or drunk driving?
   [ ] Yes  [ ] No

Have you ever experienced any injuries where you were not aware of the cause?
   [ ] Yes  [ ] No

7. Have you ever had sex (anal, oral or vaginal)?
   [ ] Yes  [ ] No

Are you currently sexually active?
   [ ] Yes  [ ] No

Are your partners men, women or both?
   [ ] Men  [ ] Women  [ ] Both men and women

What types of sexual activity have you had? Please mark all that apply.
   [ ] Anal insertive  [ ] Oral-anal
   [ ] Anal receptive  [ ] Vaginal
   [ ] Oral

How many partners have you had sex with since becoming sexually active (lifetime partners)?
   [ ] 1  [ ] 4  [ ] 11-15  [ ] Over25
   [ ] 2  [ ] 5  [ ] 16-20
   [ ] 3  [ ] 16-10

Do you feel you understand what is meant by “safer sex” practices?
   [ ] Yes  [ ] No

If you have been sexually active, what “safer sex” practices have or do you use?
   Please check all that apply.
   [ ] Condoms
   [ ] Dental dams
   [ ] In a monogamous relationship (no other sexual partners)
   [ ] Nothing
   [ ] Other barrier methods

How often do you use “safer sex” practices?
   [ ] Always (with all partners)  [ ] Sometimes
   [ ] Inconsistently  [ ] Never

Please continue on the back of this sheet. Thank you.
When do you use “safer sex” practices?
- [ ] For all types of sexual activity (oral, anal and vaginal)
- [ ] For vaginal and/or anal, but not for oral sex
- [ ] Not applicable (monogamous relationship with one sexual partner only)

Do you want any information regarding “safer sex” practices?
- [ ] Yes
- [ ] No

8. Have you urinated within the past 2 hours?
- [ ] Yes
- [ ] No

Have you ever had or do you currently have any of the following? Please check all that apply.
- [ ] Blood in the urine
- [ ] Pain or bleeding with intercourse
- [ ] Bumps or sores in the genital area
- [ ] Pain or burning with urination
- [ ] Discharge from the penis
- [ ] Problems with erections
- [ ] Frequent urination
- [ ] Rectal pain, bleeding or discharge

Do you perform a self-testicular exam?
- [ ] Yes
- [ ] No

If you perform a self-testicular exam, how often do you do it?
- [ ] Rarely
- [ ] Monthly
- [ ] Infrequently (every few months)
- [ ] Frequently (more than once per month)

Do you feel comfortable with your self-testicular exam technique? Do you feel you are doing it properly and know what you are looking for?
- [ ] Yes
- [ ] No

Do you want more information and/or instruction on the proper technique for self-testicular exam:
- [ ] Yes
- [ ] No

9. To your knowledge, have you ever been exposed to a sexually transmitted disease (STD)?
- [ ] Yes
- [ ] No

Have you ever had a sexually transmitted disease (STD)?
- [ ] Yes
- [ ] No

If you have had a STD, please mark which one(s) you have had?
- [ ] Ameba
- [ ] Chlamydia
- [ ] HPV (genital warts)
- [ ] Giardia
- [ ] Herpes
- [ ] Gonorrhea
- [ ] Molluscum contagiosum
- [ ] Hepatitis A
- [ ] NGU (non-gonococcal urethritis)
- [ ] Hepatitis B
- [ ] Scabies

Have you had the Hepatitis A vaccination?
- [ ] Yes, one shot only
- [ ] Yes, both shots
- [ ] Not sure

Have you had the Hepatitis B vaccination?
- [ ] Yes, one or two shots
- [ ] Yes, all three shots
- [ ] Not sure

10. Have you experienced increased stress in the past 30 days?
- [ ] Yes
- [ ] No

Please rate your stress level on a scale of 1-10 (10 being the highest level of stress).
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10

Do you want advice and/or referral to CAPS (Counseling and Psychological Services) regarding stress relief?
- [ ] Yes
- [ ] No

THANK YOU