NAME:________________________

DOB:________________

WELL-MALE EXAM

To help your doctor during today's health exam, please complete items 1 through 8.

1. Age:______
2. Have you had any of the following problems:

- High blood pressure ☐Yes ☐No
- Heart disease ☐Yes ☐No
- Cancer ☐Yes ☐No
- High cholesterol ☐Yes ☐No

3. Do you have any of the following problems?

- Bothersome joint pains ☐Yes ☐No
- Sexual problems (getting and keeping erections, completing intercourse,etc) ☐Yes ☐No
- Change in size/firmness of stools ☐Yes ☐No
- Change in size/color of moles ☐Yes ☐No
- Sleeping poorly or having any trouble falling or staying asleep during the past month ☐Yes ☐No
- Often feeling down, depressed or hopeless during the past month ☐Yes ☐No
- Often having little interest or pleasure doing things during the past month ☐Yes ☐No
- Difficulty with urine stream strength or flow rate ☐Yes ☐No
- Getting up frequently at night to urinate ☐Yes ☐No
- Chest pain, shortness of breath, stomach problems or heartburn ☐Yes ☐No
- Problems with falling or doing routine tasks at home ☐Yes ☐No
- Periods of weakness,numbness or inability to talk ☐Yes ☐No

4. Do you have a parent, brother or sister with a history of the following:

- Cancer of the breast, intestine or female organs ☐Yes ☐No
- Heart pain or heart attacks before the age of 55 ☐Yes ☐No

If yes to either one:

Relation______________ Type: ___________________

Relation______________ Type: ___________________

Relation______________ Type: ___________________

5. Have you ever used tobacco? ☐Yes ☐No

If yes: Average number of packs/day: _______

Number of years smoked: _______

Year quit: ______

When are you planning to quit? ☐Now ☐Next 6 months ☐Sometime ☐Never

6. Do you drink alcohol? ☐Yes ☐No

If yes:

- Have you ever felt you should cut down on your drinking? ☐Yes ☐No
- have people ever annoyed you by nagging you about your drinking? ☐Yes ☐No
- Have you ever felt guilty about your drinking? ☐Yes ☐No

NAME:____________________________

DOB:____________________

- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐Yes ☐No

7. Prevention:

- Which of the following are included in your diet:

Grains and starches	☐A lot	☐Some	☐Few
Vegetables	☐A lot	☐Some	☐Few
Dairy Foods	☐A lot	☐Some	☐Few
Meats	☐A lot	☐Some	☐Few
Sweets	☐A lot	☐Some	☐Few

- Exercise:

  Activity ________________________

  Days per week ________________________

  Time/duration ______________minutes

  Exertion: ☐Stroll ☐Mild ☐Heavy

- Do you always wear seat belts? ☐Yes ☐No
- If over 30 years old, have you had your cholesterol level checked in the past five years? ☐Yes ☐No
- Have you had a tetanus shot in the past 10 years? ☐Yes ☐No
- Does your house have a working smoke detector? ☐Yes ☐No
- How many sexual partners have you had in the last 12 months? ________ In your lifetime? ________
- When is the last time you had a dental check-up? ____________

8. Please describe any concerns your have:

____

____

____

____

____

____

____

____

Thank you for helping us get to know you!