NAME: DATE:

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:
   a. High blood pressure ☐ YES ☐ NO
   b. Heart disease ☐ YES ☐ NO
   c. Cancer ☐ YES ☐ NO
   d. High cholesterol ☐ YES ☐ NO

3. Do you have any of the following problems:
   a. Bothersome joint pains ☐ YES ☐ NO
   b. Sexual problems (getting and keeping erections, completing intercourse, etc.) ☐ YES ☐ NO
   c. Change in size/firmness of stools ☐ YES ☐ NO
   d. Change in size/color of a mole ☐ YES ☐ NO
   e. Sleeping poorly or having any trouble falling or staying asleep during the past month ☐ YES ☐ NO
   f. Often feeling down, depressed or hopeless during the past month ☐ YES ☐ NO
   g. Often having little interest or pleasure in doing things during the past month ☐ YES ☐ NO
   h. Difficulty with urine stream strength or flow rate ☐ YES ☐ NO
   i. Getting up frequently at night to urinate ☐ YES ☐ NO
   j. Chest pain, shortness of breath, stomach problems or heartburn ☐ YES ☐ NO
   k. Problems with falling or doing routine tasks at home ☐ YES ☐ NO
   l. 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:
   a. Cancer of the prostate or intestine ☐ YES ☐ NO
   b. Heart pain or heart attacks before the age of 55 ☐ YES ☐ NO

   If yes to a or b:
   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:
   a. Have you ever felt you should cut down on your drinking? ☐ YES ☐ NO
   b. Have people ever annoyed you by nagging you about your drinking? ☐ YES ☐ NO
   c. Have you ever felt guilty about your drinking? ☐ YES ☐ NO
   d. 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:
   a. 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
   b. Exercise:
      Activity _____
      Days per week _____
      Time/duration _____ minutes
      Exertion: ☐ stroll ☐ mild ☐ heavy
   c. Do you always wear seat belts? ☐ YES ☐ NO
   d. If over 30 years old, have you had your cholesterol level checked in the past five years? ☐ N/A ☐ YES ☐ NO
   e. Have you had a tetanus shot in the past 10 years? ☐ YES ☐ NO
   f. Does your house have a working smoke detector? ☐ YES ☐ NO
   g. Do you have firearms at home? ☐ YES ☐ NO
   h. How many sexual partners have you had in the last 12 months? ____ In your lifetime? ____
   i. When was your last dental check-up?_____

8. Please describe any concerns you have:

_____
_____
_____
_____
_____
_____
_____

Thank you for your help.

continued ➤

Your Doctor has the next page

NAME:

WELL-MALE EXAM CONTINUED

Date: _____

Height	Weight	Overweight	BP
		☐ YES ☐ NO	

If necessary				ALLERGIES
Temp	Pulse	Resp	O_2 Sat	

Other complaints/HPI:

Physical exam: As indicated by past medical history (none of the following are specifically recommended by USPSTF):

- Oral exam (if smoker): ☐ Normal ☐ Abnormal:
- HEENT: ☐ Normal ☐ Abnormal:
- Heart: ☐ Normal ☐ Abnormal:
- Lungs: ☐ Normal ☐ Abnormal:
- Genitourinary: ☐ Normal ☐ Abnormal:
- Abdomen: ☐ Normal ☐ Abnormal:
- Prostate: ☐ Normal ☐ Abnormal:
- Rectum: ☐ Normal ☐ Abnormal:
- Skin: ☐ Normal ☐ Abnormal:
- Extremities: ☐ Normal ☐ Abnormal:

Diagnoses (#s correspond to problem list):

Plan:

All patients:

- ☐ Handout given and reinforced healthy diet, lifestyle, exercise and safety
- ☐ Immunizations: flu, Td (q 10 yrs)
- ☐ Recommended dental exam
- ☐ Other:

Over 40 y/o:

- ☐ Cholesterol
- ☐ Coated ASA: ☐ 325 mg/d ☐ 81 mg/d

Over 50 y/o:

- ☐ Coated ASA: ☐ 325 mg/d ☐ 81 mg/d
- ☐ Immunizations: pneumococcal (>65 y/o)
- ☐ Colon cancer screen: ☐ colonoscopy ☐ ACBE ☐ flex sig ☐ stool guaiac x 3
- ☐ Calcium Rx ☐ 600 mg/d ☐ 1200 mg/d
- ☐ PSA (controversial)

Follow-Up:

- ☐ Routine visit in _____ for _____
- ☐ Physical exam in_____

Name: _____ Physician signature: _____

DOB: _____/_____/_____ Physician name: _____

Chart #: _____

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