WELL-MALE EXAM **Patient Name:** **Date of Birth:**

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 is the last time you had a dental check-up?_____

8. Please describe any concerns you have:
   _____
   _____
   _____
   _____
   _____
   _____
   _____

Thank you for your help.