

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

8. Please describe any concerns you have:

Thank you for your help.

continued ►

WELL-MALE EXAM

Date: _____

Height	Weight	Overweight <input type="radio"/> YES <input type="radio"/> NO	BP

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 R_x: 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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