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
   ■ 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 in 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:
   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
   ■ 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:  [ ] Light  [ ] Mild  [ ] Heavy
     If over 30 years old, have you had your cholesterol level checked in the past 5 years?  [ ] Yes  [ ] No
     ■ Have you had a tetanus shot in the past 10 years?  [ ] Yes  [ ] No
     ■ How many sexual partners have you had in the last 12 months?  ______
     In your lifetime?  ______

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8. Please describe any concerns you have:

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Thank you for your help.