

Name: \_\_\_\_\_  
WELL-MALE EXAM

Date: \_\_\_\_\_

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?

j. Do you take Vitamin D?

k. Do you take any other vitamins, herbs, supplements or natural remedies?

l. Do you meditate, do yoga, or participate in any form of relaxation?

m. Are spirituality or religion part of your life?

8. Please describe any concerns you have: