**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  YES  NO

keeping erections, completing

intercourse, etc.)

c. Change in size/firmness  YES  NO

of stools

d. Change in size/color of a mole  YES  NO

e. Sleeping poorly or having  YES  NO

any trouble falling or staying

asleep during the past month

f. Often feeling down, depressed  YES  NO

or hopeless during the past month

g. Often having little interest or  YES  NO

pleasure in doing things during

the past month

h. Difficulty with urine stream  YES  NO

strength or flow rate

i. Getting up frequently at night  YES  NO

to urinate

j. Chest pain, shortness of breath,  YES  NO

stomach problems or heartburn

k. Problems with falling or doing  YES  NO

routine tasks at home

l. Periods of weakness, numbness  YES  NO

or inability to talk

4. Do you have a parent, brother or sister with a history of

the following:

a. Cancer of the prostate  YES  NO

or intestine

b. Heart pain or heart attacks  YES  NO

before the age of 55

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  YES  NO

cut down on your drinking?

b. Have people ever annoyed you  YES  NO

by nagging you about your drinking?

c. Have you ever felt guilty about  YES  NO

your drinking?

d. Have you ever had a drink first  YES  NO

thing in the morning to steady your

nerves or get rid of a hangover?

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  N/A  YES  NO

had your cholesterol level checked

in the past five years?

e. Have you had a tetanus shot  YES  NO

in the past 10 years?

f. Does your house have a working  YES  NO

smoke detector?

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.*

Form continues on next page >

**WELL-MALE EXAM**

--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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

|  |  |  |  |
| --- | --- | --- | --- |
| Height | Weight | Overweight | BP |
|  |  | M YES M NO |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| If necessary | | | | ALLERGIES |
| Temp | Pulse | Resp | O2 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 m 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 #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developed by Peter A. Cardinal, MD, MHA, Gettysburg Hospital, Gettysburg, Pa. Copyright © 2003 American Academy of Family Physicians. Physicians may photocopy or adapt for use in their own practices; all other rights reserved. “Encounter Forms for Better Preventive Visits.” Cardinal PA. *Family Practice Management.* July/August 2003:35-40, http://www.aafp.org/fpm/20030700/35enco.html.