**WELL-MALE EXAM**

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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Thank you for your help.*

Form continues on next page >

**WELL-MALE EXAM**

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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 #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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