WELL-MALE EXAM ENCOUNTER FORM

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 was your last dental check-up?______________________

8. Please describe any concerns you have:

____

____

____

____

____

____

Thank you for your help.

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

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Date ______________________________

Height	Weight	Overweight	BP
		☐ Yes ☐ No	

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 35 y/o:

☐ Cholesterol

Over 50 y/o:

☐ 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: _______ / _______ / _______ Chart #: __________________ Physician name: ______________________________