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 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?

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.
WELL-MALE EXAM CONTINUED

Date: ____________________

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<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Overweight</th>
<th>BP</th>
<th>Temp</th>
<th>Pulse</th>
<th>Resp</th>
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☐ YES  ☐ NO

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 ☐ 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 #: ____________________