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 pain   □ 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?   □ 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

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If necessary

Allergies

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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: _________________________________________________________