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? ❍ 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 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.