Flathead Valley
Community College™

Student Health Clinic

Name________________________________ **Date of Birth**________________

Well Male Exam Questionnaire

Are you concerned about any of the following? (circle yes or no and specific problem)

Eating habits: weight gain or loss, sleep habits…………………………………………………….yes no
Eye redness, pain, increased tearing, drainage, blurred, decreased vision …………… yes no
Ear pain, decreased hearing ………………………………………………………………………………. yes no
Heart problems, chest pain, palpitations, blood pressure, leg swelling ………………….yes no
Lung problems, difficulty breathing, wheezing, cough …………………………………………… yes no
Abdominal pain, nausea, vomiting, diarrhea, constipation, bloody stool ………………..yes no
Kidney or bladder problems, infection, blood in urine …………………………………………… yes no
Joint pain, stiffness, swelling, muscles pain or weakness ……………………………………… yes no
Skin, rash, itching, dryness, hair or nail problems …………………………………………………yes no
Recurrent headaches, dizziness, numbness, weakness ……………………………………………yes no
Stress, anxiety, sadness, depression, suicidal thoughts ………………………………………… yes no
Excessive thirst or hunger, increased urination, weight loss …………………………………yes no
Paleness, anemia, easy bruising, swollen glands …………………………………………………… yes no
Allergies, hay fever, asthma, infections …………………………………………………………………. yes no

Comments____
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Personal History

Are you concerned about any of the following? (circle yes or no)

Penis or testicles. …………………………………………………………………………………………………….yes no
Prostate…………………………………. ………………………………………………………………………………yes no
Erections or intercourse……………………………………………………………………………………………yes no
Sexually transmitted diseases, AIDS, other sexual concerns ……………………………………yes no
Are you sexually active? ……………………………………………………………………………………………yes no

Comments____
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Name_______________________________________ **Date of Birth**____________________

Social History

Are you: single married divorced widowed ?

Do you feel safe at home, in your relationships with family/partner? ....yes no

Do you smoke or use tobacco products? ....yes no

If yes, how many packs/cans per day? ______________ How many years? ________________

Do you or have you ever used recreational drugs? ....yes no

If yes, type ________________________ frequency? _________________________

Do you drink alcohol? ....yes no

If yes, how many per day? _____________ per week? __________________

Do you always use a seat belt in a vehicle? ....yes no

Exercise information: Do you exercise regularly?________What type and how often_________

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Preventative Health History

Have you ever had a PSA (prostate) blood test?..yes no

When?______________ Was it normal?..yes no

Have you ever had a colonoscopy? ....yes no

Have you ever had your cholesterol checked?...yes no

When? ___________________ Was it normal? ....yes no

Have you had a tetanus shot in the past 10 years?.. yes no

When? _______________

Personal/Family History

Have **<u>you</u>** had any of the following?

Prostate Cancer yes no when?___________________

Colon Cancer yes no when?___________________

Osteoporosis yes no when?___________________

Heart disease yes no when?___________________

Heart attack before age 55 yes no when?___________________

Have any **<u>close relatives</u>** had any of the following?

Prostate Cancer yes no who? ______________________________________

Osteoporosis yes no who? ______________________________________

Heart Disease yes no who? ______________________________________

Heart attack before the age of 55 yes no who? ______________________________________

Do you have any concerns you wish to discuss?____

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Patient signature____**Date**_____________