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

______________________________________________________________________

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

______________________________________________________________________

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 use 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

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 you 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 close relatives 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?

Patient signature Date