Well – Male Exam

Date: _____

To help your doctor during today's health exam, please complete items 1 through 12.

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 take any of the following pills:

a. Multivitamins	☐ Yes	☐ No
b. Calcium	☐ Yes	☐ No
c. Supplements, Herbs	☐ Yes	☐ No

4. 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	☐ Yes	☐ No
k. Shortness of breath	☐ Yes	☐ No
l. Heartburn or stomach problems	☐ Yes	☐ No
m. Problems with falling or doing routine tasks at home.	☐ Yes	☐ No
n. Periods of weakness, numbness or inability to talk	☐ Yes	☐ No
o. Any problems with hearing	☐ Yes	☐ No
p. Stress in your family or relationship? Has anyone hurt you?	☐ Yes	☐ No

5. Do you have a parent, brother or sister with a history of the following:

a. Cancer of the prostate, colon or breast	☐ Yes	☐ No
b. Heart pain or heart attacks before the age of 55	☐ Yes	☐ No
c. Diabetes	☐ Yes	☐ No

If yes to a, b, or c:
Relation: _____ Type: _____
Relation: _____ Type: _____

6. 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

7. 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

8. Do you use marijuana, cocaine or other street drugs? ☐ Yes ☐ No

9. Do you feel safe at home? ☐ Yes ☐ No

10. How comfortable are you with your reading?
☐ very comfortable ☐ Somewhat comfortable ☐ No comfortable at all

11. 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
Fruits	☐ A lot	☐ Some	☐ Few
Nuts	☐ A lot	☐ Some	☐ Few

b. Exercise:
Activity: _____
Days per week: _____
Time/duration _____
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. Does your partner have sex with anyone else? ☐ Yes ☐ No

j. Do you practice safe sex? ☐ Yes ☐ No

k. Do you use condoms? ☐ Yes ☐ No

l. Do you have sex with women, men or both? _____

m. When is the last time you had a dental check-up? _____

12. Please describe any concerns you have: _____

_____

_____

_____

_____

_____

_____

_____ *Thank you for your help.*

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

Patient Signature: _____ Date: _____ Time: _____

Questionnaire reviewed and discussed with patient

MD/MLP Signature: _____ Date: Time:

NOVANT HEALTH NHMG

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Name / MR # / Label