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 ☐ o
   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

   For men over 50, have you had the shingles vaccine? ☐ 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.

AAFP FPM

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