WELL-MALE EXAM

FPM Tool

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: _____

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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.

continued ➤

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   f. Does your house have a working smoke detector? ○ YES ○ NO
   g. Do you have firearms at home? ○ YES ○ NO
   h. Have you ever had a mammogram? ○ YES ○ NO

      If yes, date of last: _____ where: _____

      Have you ever had any abnormal mammograms? ○ N/A ○ YES ○ NO

      If yes, date: _____ problem: _____

      For abnormality, did you have any of the following:

Biopsy	○ YES	○ NO
Cyst fluid drained	○ YES	○ NO
Surgery	○ YES	○ NO

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

11. Please describe any concerns you have:

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Thank you for your help.

Continued ➤