MALE - COMPLETE PHYSICAL/PREVENTION **NAME:** **DATE:**

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, heart disease, diabetes, or high cholestorol: □ YES □ NO

   b. Cancer: □ YES □ NO

3. Do you have any of the following problems:
   a. Bothersome joint pain; pain in the muscles: □ YES □ NO

   b. Sexual problems (getting and keeping erections, completing intercourse, etc.): □ YES □ NO

   c. Change in size/firmness of stools; diarrhea, constipation: □ 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. Severe headaches: □ YES □ NO

   g. Often feeling down, depressed or hopeless during the past month: □ YES □ NO

   h. Often having little interest or pleasure in doing things during the past month: □ YES □ NO

   i. Difficulty with urine stream strength or flow rate; pain or incontinence : □ YES □ NO

   j. Getting up frequently at night to urinate: □ YES □ NO

   k. Chest pain, shortness of breath; palpitations: □ YES □ NO

   l. Stomach problems or heartburn; nausea: □ YES □ NO

   m. Problems with falling or doing routine tasks at home: □ YES □ NO

   n. Periods of weakness, fatigue, numbness, inability to talk or dizziness: □ 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 50: □ YES □ NO

   c. Diabetes: □ YES □ NO

   If yes to a, b or c:
   Relation: __________________ Type: ____________________

   Relation: __________________ Type: ____________________

5. Have you ever smoked: □ 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
   Have you been diagnosed with asthma/ COPD(Emphysema): □ YES □ NO

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:

Cereals / fibers	□ a lot	□ some	□ few
Vegetables/fruits	□ a lot	□ some	□ few
Dairy foods	□ a lot	□ some	□ few
Meats	□ a lot	□ some	□ few
Sweets/starches	□ 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. Last prostrate exam: __________________

   f. Have you had a tetanus shot in the past 10 years: □ YES □ NO

   g. Does your house have a working smoke detector: □ YES □ NO

   h. Do you have firearms (guns) at home: □ YES □ NO

   i. How many sexual partners have you had in the last 12 months: ____ In your lifetime: ____

   j. When is the last time you had a dental check-up:________

8. Please describe any concerns you have:
____
____
____
____
____
____

Thank you for your help.

Form continues on next page >

MALE PHYSICAL EXAM

Weight/BMI	Height	Abd. Circumf.	BP	Temp	Pulse	Resp	O2 Sat	Allergies

☑ Normal ☒ Abnormal _______________ M.A.

Skin ☐

HEENMT ☐

Neck/Thyroid ☐

Spine ☐

Chest/Lungs ☐

CV/Heart ☐

Abdomen ☐

Lymph Nodes ☐

Genitourinary/Rectum ☐

Prostate ☐

MSK/Extremities ☐

Peripheral Vascular ☐

Neuro System ☐

Psych. ☐

Diagnosis:

Plan:

All patients:

- ☐ Handout given and reinforced healthy diet, lifestyle, exercise and safety
- ☐ Immunizations: flu, Td/p (q 10 yrs)
- ☐ Recommended dental exam

Over 40 y/o:

- ☐ BB ASA, 81 mg/d

Over 50 y/o:

- ☐ BB ASA, 81 mg/d
- ☐ Immunizations: pneumococcal (>65 y/o)
- ☐ Colon cancer screen: ☐ colonoscopy ☐ stool guaiac x 3
- ☐ Calcium Rx: ☐ 600 mg/d ☐ 1200 mg/d
- ☐ PSA (controversial)
- ☐ Flu Vaccination q 1 yr

☐ Return to office: Days ____________Week(s)_____________Month(s)_____________ ☐PRN

☐ Referral

Physician signature: ____Date: ________________