



**BAY VALLEY
MEDICAL GROUP**

Patient Name: _____

MRN: _____

Well-Male Exam

To help your doctor during today's 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 difficulty falling 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
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 | <input type="radio"/> a lot | <input type="radio"/> some | <input type="radio"/> few |
| Vegetables | <input type="radio"/> a lot | <input type="radio"/> some | <input type="radio"/> few |
| Dairy foods | <input type="radio"/> a lot | <input type="radio"/> some | <input type="radio"/> few |
| Meats | <input type="radio"/> a lot | <input type="radio"/> some | <input type="radio"/> few |
| Sweets | <input type="radio"/> a lot | <input type="radio"/> some | <input type="radio"/> 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? 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:

If yes to a or b:

Relation: _____ Type: _____

Relation: _____ Type: _____

Thank you for completing this form