Name:_____ WESTSHORE PRIMARY CARE **WELL-MALE EXAM** v2.4

To help your doctor during today's health exam, please complete items 1 through 6.

1. 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
e. Other _____
f. Surgeries _____
_____

2. 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/color of a mole ☐YES ☐NO
d. Change in size/firmness of stools ☐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

3. Do you have a parent, brother, sister or close family member with any of the following:

Breast Cancer, Colon Cancer, Uterine Cancer, Heart attacks, Diabetes, High cholesterol, High blood pressure, or other medical problems?

If so explain:

Mother:_____

Father: _____

Brother: _____

Sister: _____

Other:_____

4. 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

5. 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

6. 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 _____ ☐do not exercise
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?_____

Thank you for your help.

Physician reviewed_____

Name_____ **HT**_____ **BP**_____ **P**_____**R**_____ **T**_____

Age_____**DOB**_____**Date** _____ **WT**_____**lb** **BMI**_____ **Med sheet rev.**☐

HPI: **Allergies:**

Exam	wnl	See note	
General			NAD, Cooperative
Skin			no Rash
HEENT			PERRLA, TMs clear, nl Mucosa
Neck			Supple, Thyroid nl
Heart			RRR without Murm/ rub/gall/thrill
Lungs			CTA bilat. Equal breath sounds
Abdomen			Soft, NT, nl BS, no Mass
Extremities			no Edema, nl Pulses
Psych			nl Affect
Neuro			Equal Reflexes, Sensation nl, Gait nl
Lymph			no Adenopathy
Musc/skeletal			Strength equal, no Deformity
Genital			nl Phallus, Testis smooth and oval
Rectal			nl Tone, no Mass, Heme neg

Assessment:

All patients:

☐Reinforced healthy diet, lifestyle, exercise and safety
☐Recommended Coated **ASA 81** mg/d
☐**Dental exam** recommended
Cholesterol: ☐screen ordered ☐rev. on chart_____
Blood Screening ordered:

_____

☐**Flu shot** recommended ☐patient declines ☐**UTD**
☐**Td/Adacil** recommended ☐patient declines ☐**UTD**
☐**Meningitis** vaccine rec. ☐patient declines ☐**UTD**
☐**Zostavax** recommended ☐patient declines ☐**UTD**
UTD for: ☐HepB ☐MMR ☐Varicella

Over 50 y/o:

☐EKG
☐ Pneumovax (>65 y/o) recommended
Colon cancer screen: ☐colonoscopy referral
☐stool guaiac x 3 cards given
☐Calcium advised: ☐600 mg/d ☐1200 mg/d
☐Prostate: Discussed pros and cons of screening
☐PSA ordered
☐Patient declines screening

Follow up: _____ days/weeks/months/year

WESTSHORE PRIMARY CARE

Physician signature: _____