

MEN'S ANNUAL EXAM: CONFIDENTIAL MEDICAL REVIEW AND UPDATE

NAME: _____ Age: _____ Date: _____
Reason for today's appointment: _____

GENERAL MEDICAL HISTORY AND REVIEW

- Do you have any major health concerns today? N Y
- Any major illness, injury, surgery or hospitalization since your last visit? N Y
- Any problems with eating or with your stomach or bowels? N Y
- Any problems with chest pain, palpitations or your heart? N Y
- Any problems with shortness of breath or cough? N Y
- Any new, changed, dark, large, itchy, bleeding or irregular moles? N Y
- Any problems with eyes, ear, nose, throat, skin or nerve problems? N Y
- Have you noticed any pain or lumps in your testicles? N Y
- Any problems with urinary frequency, decreased urine flow, difficulty starting urination or excessive night-time urination? N Y How many times do you get up At night to urinate? _____
- Any significant loss or increase in your weight? N Y
- Are you a heavy snorer? N Y
- Have you had problems with fatigue or day-time sleepiness? N Y
- Any problems with insomnia or waking up too early? N Y
- Are you sometimes so sad or anxious that you think about dying? N Y
- Any major current social stresses (circle): marriage, divorce, separation, Financial, legal, work, deaths, housing, family, relationships, illness? N Y
- Any updates on your family medical history? N Y

FAMILY PLANNING & SEXUAL HISTORY

- Sexual partner are: (circle) M F Both Birth control method _____
- Are you currently sexually active? N Y
- Have you had a new sexual partners in the past 3 months? N Y How long have you been with your current partner? _____
- Do you sometimes have sex without a birth control method? N Y
- Is your partner pregnant? N Y
- Are you and your partner trying to get pregnant or planning to try? N Y
- Do you sometimes have sex without using a condom? N Y
- Any history of sexually transmitted diseases (STD)? (circle) N Y Total number of partners in the past 5 years? _____
HIV; herpes; genital warts; gonorrhea; Chlamydia; trichomonas
- Are you concerned that you or your partner might have a STD? N Y
- Any drip or discharge from your penis or pain with urination or sex? N Y
- Have you had or do you have any sores or rashes on your penis? N Y
- Would you like to be checked confidentially for HIV or other STD? N Y
- Have you had problems achieving or maintaining an erection? N Y
- Would you like info. About the No Scalpel Vasectomy offered here? N Y

REVIEW ALL DRUG ALLERGIES

PLEASE TURN OVER

REVIEW OF ALL MEDICATIONS YOU ARE TAKING:

(Include occasional & over-the-counter medications, as well as vitamins, aspirin, laxatives & supplements)

Medication	Dosage	Taken how often	what for?

Do you take a multiple vitamin daily? _____ Calcium? _____

HEALTH HABITS AND HEALTH MAINTENANCE REVIEW

Do you smoke cigarette or use any other tobacco products?	N	Y	# packs per day _____
Do you live or work with a smoker or are you regularly exposed to smoke?	N	Y	
Do you drink alcohol?	N	Y	Avg. # drinks per day _____
Do you think you need to cut back on your drinking?	N	Y	
Has anyone else ever advised you to cut back on your drinking?	N	Y	
Do you drink coffee, tea, chocolate, soda or other caffeinated drinks?	N	Y	Avg. total cups per day _____
Are you using street, recreational or illegal drugs?	N	Y	
Would you like help losing weight?	N	Y	
Do you routinely add salt to most of your food?	N	Y	
Do you eat black licorice regularly?	N	Y	
Do you have a problem with anger, rage or controlling your temper?	N	Y	
Do you have a firearm in your home?	N	Y	How is it stored? _____
Are you mostly sedentary or not doing any formal exercise?	N	Y	Type & Hours/Week? _____
Would you like instruction on how to perform a self testicular exam?	N	Y	
Do you perform a monthly self testicular exam?	N	Y	
Any exposure in your workplace to chemical, radiation or noise hazards?	N	Y	What type? _____
Has it been more than 10 years since your last Tetanus shot?	N	Y	
Would you like to get an annual flu shot?	N	Y	
Would you like to have your cholesterol checked?	N	Y	
Has it been more than 1 year since your last dental exam?	N	Y	
Do you ever travel without a seat belt or bicycle without a bicycle helmet?	N	Y	

Approximately how many years has it been since your last:

Chest X-ray? _____ EKG (Electrocardiogram)? _____ Complete eye exam? _____ TB skin test? _____
 Colon cancer screening by hem cult cards? _____ By Colonoscopy or Flexible sigmoidoscopy? _____
 Pneumonia immunization? _____

SOCIAL HISTORY (OPTIONAL)

Who do you live with? _____
 Occupation and Type of Work _____ Currently working? Y N
 Marital Status: (circle) Single Never married Divorced Separated Married Significant other of _____ years