Well Male Exam

Center for Integrative Health

Date: **Name:** **Age:** **Date of Birth:**

Last **First** **M.I.** **(Preferred)**

Marital Status (please circle): Single Married Separated Divorced Widowed

Occupation:

What is the main reason you came in today?

Family History

YES **NO**

☐ ☐ History of cancer, Melanoma, Breast, Colon, Prostate, Other:_____

Have any members of your immediate family (biological parents or siblings) had any of the following? If YES, please explain and indicate which member by using the appropriate abbreviation:
M= Mother **F** = Father **S**= Sister **B**= Brother circle all that apply

☐ ☐ High cholesterol, hypertension or Heart disease (Explain)_____

☐ ☐ Diabetes, Thyroid Disease (Explain)_____

☐ ☐ Lung problem, Asthma (Explain)_____

☐ ☐ Colon or stomach problems- ulcers, gall stones, colon polyps, ulcerative colitis Other:_____

☐ ☐ Neurologic or Psychiatric or addictive disorder (Explain)_____

☐ ☐ Kidney, Prostate or Bladder problems (Explain)_____

☐ ☐ Blood or skin problems, Glaucoma (Explain)_____

Other:

Past Personal Medical History

YES **NO** Do <u>you</u> have a past medical history of the following

☐ ☐ Cancer (Explain)_____

☐ ☐ Blood pressure, heart or lung or cholesterol problem (Explain)_____

☐ ☐ Thyroid or blood sugar problems (Explain)_____

☐ ☐ Blood clots severe migraine headaches (Explain)_____

☐ ☐ Stomach, colon, liver problems (Explain)_____

Other:_____

Do You Experience Current Medical Complaints With Your…

YES **NO**

☐ ☐ Eyes, ears throat, lungs? (Explain)_____

☐ ☐ Severe headaches, fatigue, dizziness? (Explain)_____

☐ ☐ Chest or heart or breasts? (Explain)_____

☐ ☐ Stomach, abdomen or colon? (Explain)_____

Other:_____

Immunization Diary- Indicate <u>date</u> of last shot.

Flu:	Measles:	Tetanus:
Hepatitis B:	Pneumovax:	BCG (T.B. Vaccine):
Tuberculosis(TB) Skin Test:	Results:	Other Vaccines:

Review of Genito-urinary History –Indicate History for Past 6 Months

YES **NO** If response is YES, please explain.

☐ ☐ Has there been a change in your urinary pattern? (Get up to urinate more than once per night, painful urination, prostate problems, blood in urine, difficulty) Other:_____

☐ ☐ Any urethral discharge, ulcers or bumps around the genitals? (Explain)_____

_____

☐ ☐ Do you do testicular self-exams monthly? (For patients under 45 years)
If not, would you like additional instructions or information? ☐ Yes ☐ No

☐ ☐ Do you feel your weight is optimal? What do you think you should weigh?_____ How tall are you? ____

☐ ☐ Has your cholesterol level been checked in the last 3years?
Results: ☐ Normal ☐ Abnormal- Explain_____

What else concerns you about your health?_____

What one issue specifically concerns you the most about your health?_____