WELL MALE EXAM

1. Do you have any of the following problems: (If "YES", please circle appropriate area or describe below.)

A) Bothersome joint pains? _____ **YES NO**
B) Broken a bone in the last 10 years? _____ **YES NO**
C) Change in size/firmness of stools? _____ **YES NO**
D) Change in size/color of a mole, or do you have a rash (ANYwhere)? _____ **YES NO**
E) Having trouble falling or staying asleep during the last month? _____ **YES NO**
F) Often feeling down, depressed, or hopeless during past month? _____ **YES NO**
G) Often having little interest/pleasure in doing things in the past month? _____ **YES NO**
H) Notice blood in urine or stool? _____ **YES NO**
I) Difficulty with urine stream, length, or flow rate? _____ **YES NO**
J) Getting up more than 2 times at night to urinate? _____ **YES NO**
K) Sexual problems (getting or keeping erections, etc) _____ **YES NO**
L) Chest pains, shortness of breath, stomach problems, heartburn? (Circle specific problem, if so) **YES NO**
M) Do you snore? _____ **YES NO**
N) Do you have seasonal allergies or hay-fever? _____ **YES NO**

2. Tobacco: I quit ___ years ago. I last tried to quit _____ago. I have no interest in quitting. Ever tried Chantix? **Yes No**

3. Do you drink alcohol? **YES NO** If yes: Average drinks per week:____-____

A. Do you feel you should cut down on your drinking? **YES NO**
B. Do people annoy you by nagging about your drinking? **YES NO**
C. Have you ever felt guilty about your drinking? **YES NO**
D. Have you drank in the morning to steady your nerves**?** **YES NO**

4. Do you know your cholesterol level? _____ **YES NO**

5. When was your last prostate exam? _____ PSA? _____

6. How many days per week do you exercise? _____ Circle level of exertion: **Stroll Mild Heavy**

7. Do you take aspirin daily? **YES NO** If yes: **81mg** or **325mg**?

8. Vaccines: Please circle: **Tetanus** (Within the past 10 yrs) **Pneumococcal** (If 65 yrs old) **Shingles** (If 60 yrs old) **Flu**

9. Colon Cancer Screening: When was your last: Colonoscopy? _____ Stool Cards? _____

10. When was the last time you had a dental check-up? _____ Eye Exam? _____

11. What over-the-counter medicines do you take? _____
_____

Please describe any concerns you have? _____
_____

Any specific prayer requests? _____

Reviewed with patient (Stewart Tankersley, M.D.): _____ Date:(same as visit) _____

Please Complete NAME:_____ DOB_____ AGE:____ DATE___/____/____