Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

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

If yes, describe: _____

Any major illness, injury, surgery, or hospitalization since your last visit.....N Y

Any problems with eating or your stomach or bowels?.....N Y

Any problems with chest pain, palpitations, or heart?.....N Y

Any problems with shortness of breath or cough?.....N Y

Any new, changed, dark, large, itching, 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 weight loss or weight gain?.....N Y

Are you a heavy snorer?.....N Y

Have you had any problems with fatigue of 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

If yes, describe: _____

FAMILY PLANNING & SEXUAL HISTORY

Sexual partners are (circle): M F Both

Are you currently sexually active?.....N Y

Have you had a new sexual partner in the past three months?.....N Y

How long have you been with your current partner? _____ Is your partner pregnant?.....N Y

Do you have any questions or concerns about sex or birth control?.....N Y

Birth control method: _____

Do you sometimes have sex without a birth control method?.....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 Transmitting Diseases (STD)?.....N Y

(Circle): HIV, herpes, genital warts, gonorrhea, chlamydia, trichomonas

Total number of partners in the past five years? _____

Are you concerned that you or your partner might have a STD?.....N Y

Any drop 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 liked to be checked confidentially for HIV or any other STD?.....N Y

Have you had any problems achieving or maintaining an erection?.....N Y

Would you like information about the No Scalpel Vasectomy offered here?.....N Y

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Men's Annual Exam (back page)

DRUG ALLERGIES: _____

CURRENT MEDICATIONS (Include occasional and over the counter medications, vitamins, aspirin, laxatives, and supplements)

Medication	Dosage	Taken how often?	Taken for what reason?

Do you take a multi vitamin daily? N Y Calcium? N Y

HEALTH HABITS AND HEALTH MAINTENANCE REVIEW

Do you smoke cigarettes or use any other tobacco products?.....N Y
How many per day (on average)? _____ Do you live or work with a smoker?.....N Y
Do you drink alcohol?.....N Y
Average number of drinks per day _____ Do you think you need to cut back on your drinking?.....N Y
Do you drink coffee, tea, sodas, or other caffeinated drinks?.....N Y
Average drinks/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 foods?.....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 and hours per week of exercise: _____
Would you like instructions on how to perform a self testicular exam?.....N Y
Any exposure in your workplace to chemical, radiation, or noise hazards?.....N Y
Please describe:_____
Has it been more than ten 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 one year since your last dental exam?.....N Y
Seatbelt worn: Always / Occasional / Never Bike helmet worn: Always / Occasional / Never
Approximate **date** of last:
Chest X-Ray_____ EKG (electrocardiogram)_____ Complete eye exam_____ Pneumonia shot _____
Colon cancer screening: hemoccult cards _____ or colonoscopy/flexible sigmoidoscopy _____

SOCIAL HISTORY (optional)

Who do you live with? _____
Occupation and type of work: _____ Currently working?.....N Y
Marital status: Single __ Married ___ (how many years: ___) Divorced ____ Never Married ___ Separated ____