HealthCircle Primary Care Clinic
UNIVERSITY OF COLORADO COLORADO SPRINGS

Name:

Date:

Well-Male Exam History Form

(To help your practitioner during today's exam, please complete items 1-7)

1. ***Have you had any of the following problems?***
   - a. High Blood Pressure ☐ YES ☐ NO
   - b. Heart Disease ☐ YES ☐ NO
   - c. Diabetes ☐ YES ☐ NO
   - d. Cancer ☐ YES ☐ NO
   - e. High Cholesterol ☐ YES ☐ NO
   - f. Lung Disease ☐ YES ☐ NO

2. ***Do you have any of the following problems?***
   - a. Muscle or joint pains ☐ YES ☐ NO
   - b. Frequent headaches ☐ YES ☐ NO
   - c. Weight loss or gain ☐ YES ☐ NO
   - d. Fatigue ☐ YES ☐ NO
   - e. Eye problems – vision, pain, tearing ☐ YES ☐ NO
   - f. Ear, nose, mouth, throat problems ☐ YES ☐ NO
   - g. Chest pain ☐ YES ☐ NO
     If YES when?
   - h. Shortness of breath or lung problems ☐ YES ☐ NO
   - i. Heartburn or stomach problems ☐ YES ☐ NO
   - j. Getting up frequently at night to urinate ☐ YES ☐ NO
   - k. Difficulty with urine stream or flow rate ☐ YES ☐ NO
   - l. Change in size/firmness of stools ☐ YES ☐ NO
   - m. Changes in size/color of a mole on your skin ☐ YES ☐ NO
   - n. Skin changes / itching or rashes ☐ YES ☐ NO
   - o. Sleeping poorly or having problems falling or staying asleep ☐ YES ☐ NO
   - p. Feeling down, depressed or hopeless in during the last month ☐ YES ☐ NO
   - q. Having little interest or pleasure in doing things in the last month ☐ YES ☐ NO
   - r. Sexual problems – getting or keeping an erection, completing intercourse, or other concerns ☐ YES ☐ NO
   - s. Addiction to drugs or alcohol ☐ YES ☐ NO
   - t. Dizziness or numbness ☐ YES ☐ NO
   - u. Blood clots or bruising ☐ YES ☐ NO
   - v. Food allergies, hay fever eczema ☐ YES ☐ NO

3. Do you have a parent of sibling with a history of the following:

   - a. Cancer of the prostate or intestine ☐ YES ☐ NO
   - b. Other cancers ☐ YES ☐ NO

   If YES – type of cancer

   - c. Heart attack before 55 ☐ YES ☐ NO
   - d. Diabetes ☐ YES ☐ NO
   - e. Thyroid problems ☐ YES ☐ NO
   - f. Liver problems ☐ YES ☐ NO
   - g. Lung problems ☐ YES ☐ NO
   - h. Kidney problems ☐ YES ☐ NO
   - i. Mental illness ☐ YES ☐ NO

4. Have you ever used tobacco?

If you have in the past or do now…

   - a. Number of packs/day:
   - b. Number of years smoking:
   - c. Year you quit:
   - d. IF you smoke now do you plan to quit?

☐ Now ☐ In 6 months ☐ Maybe ☐ Never

5. Do you drink alcohol?

If you do drink now….

a. Have you been annoyed by someone talking to you about your drinking?

☐ YES ☐ NO

b. Have you felt like you should cut down on the amount that you drink ☐ YES ☐ NO

c. Have you ever felt guilty about the amount of alcohol that you drink? ☐ YES ☐ NO

d. Have you ever had a drink right after you woke up in the morning? ☐ YES ☐ NO

6. Prevention:

a. How often do you exercise?

☐ never ☐ once a week ☐ 2-4 x a week

☐ 5-7 x a week ☐ every day

What is your activity?

How long do you exercise?

Intensity?

b. Do you wear seatbelts? ☐ YES ☐ NO

c. Do you use sunscreen?

☐ All the time ☐ Most of the time

☐ Some of the time ☐ Never

d. Are any firearms locked and away from children ☐ YES ☐ NO

e. What does your diet consist of:

Whole grains	☐ many	☐ some	☐ few
Vegetables	☐ many	☐ some	☐ few
Dairy foods	☐ many	☐ some	☐ few
Lean meats	☐ many	☐ some	☐ few
Sweets & fats	☐ many	☐ some	☐ few
Caffeine drinks	☐ many	☐ some	☐ few
Processed foods	☐ many	☐ some	☐ few
Fast Food	☐ many	☐ some	☐ few
Sodas	☐ many	☐ some	☐ few
Water	☐ much	☐ some	☐ few

f. Have you had a tetanus shot in the last 10 years? ☐ YES ☐ NO

g. How many sexual partners in the

last 12 months?

In your lifetime?

h. Have you had your cholesterol checked?

☐ YES ☐ NO

i. Have you had your blood sugar checked?

☐ YES ☐ NO

j. Do you take a baby aspirin each day?

☐ YES ☐ NO

k. Are you at risk for having a sexually transmitted disease?

☐ YES ☐ NO

7. Other Concerns