Patient:________________________ Date:____________________

DOB:_____________

Lone Peak Primary Care

affiliated with St. Mark's Hospital

WELL-MALE EXAM HISTORY

-

To help your doctor during today's health exam, please complete items 1 through 8.

1. Age: _______

2. Have you had any of the following problems:
   - a. High blood pressure □ YES □ NO
   - b. Heart disease □ YES □ NO
   - c. Cancer □ YES □ NO
   - d. High cholesterol □ YES □ NO

3. Do you have any of the following problems:
   - a. Bothersome joint pains □ YES □ NO
   - b. Sexual problems (getting and keeping erections, completing intercourse, etc.) □ YES □ NO
   - c. Change in size/firmness of stools □ YES □ NO
   - d. Change in size/color of a mole □ YES □ NO
   - e. Sleeping poorly or having any trouble falling or staying asleep during the past month □ YES □ NO
   - f. Often feeling down, depressed or hopeless during the past month □ YES □ NO
   - g. Often having little interest or pleasure in doing things during the past month □ YES □ NO
   - h. Difficulty with urine stream strength or flow rate □ YES □ NO
   - i. Getting up more than once at night to urinate □ YES □ NO
   - j. Chest pain, shortness of breath, stomach problems or heartburn □ YES □ NO
   - k. Problems with falling or doing routine tasks at home □ YES □ NO
   - l. Periods of weakness, numbness or inability to talk □ YES □ NO

4. Do you have a parent, brother or sister with a history of the following:
   - a. Cancer of the prostate or intestine □ YES □ NO
   - b. Heart pain or heart attacks before the age of 55 □ YES □ NO

   If yes to a or b:

   Relation: _____________________ Type: ____________

   Relation: _____________________ Type: ____________

5. Have you ever used tobacco? □ YES □ NO

   If yes:

   Average number of packs/day: ______

   Number of years smoked: _______

   Year quit: ________

   When are you planning to quit?

   □ now □ next 6 months □ sometime □ never

6. Do you drink alcohol? □ YES □ NO

   If yes:
   - a. Have you ever felt you should cut down on your drinking? □ YES □ NO
   - b. Have people ever annoyed you by nagging you about your drinking? □ YES □ NO
   - c. Have you ever felt guilty about your drinking? □ YES □ NO
   - d. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? □ YES □ NO

7. Prevention:
   - a. Which of the following are included in your diet:

Grains and starches	□ a lot	□ some	□ few
Vegetables	□ a lot	□ some	□ few
Dairy foods	□ a lot	□ some	□ few
Meats	□ a lot	□ some	□ few
Sweets	□ a lot	□ some	□ few

   - b. Exercise:

     Activity _______________________________________

     Days per week________

     Time/duration ________ minutes

     Exertion: □ stroll □ mild □ heavy
   - c. Do you always wear seat belts? □ YES □ NO
   - d. If over 30 years old, have you had your cholesterol level checked in the past five years? □ NA □ YES □ NO
   - e. Have you had a tetanus shot in the past 10 years? □ YES □ NO
   - f. Does your house have a working smoke detector? □ YES □ NO
   - g. Do you have firearms at home? □ YES □ NO
   - h. How many sexual partners have you had in the last 12 months? _____ In your lifetime? ______
   - i. When is the last time you had a dental check-up? ___________

8. Please describe any concerns you have:

____

____

____

____

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Thank you for your help.