Patient Name: _____ Date Birth: _____ Age: _____

GCH Clinics
Well Male Exam

Please complete before your appointment for a physical

Are you having any problems with: – (Please circle either yes or no)

Skin changes	Yes	No		Heartburn	Yes	No		Fatigue	Yes	No		Slow urinary stream	Yes	No
Changes in mole	Yes	No		Abdominal Pains	Yes	No		Back pains	Yes	No		Urinating at night	Yes	No
Severe headaches	Yes	No		Constipation	Yes	No		Sleeping poorly	Yes	No		Urinary frequency	Yes	No
Vision Problems	Yes	No		Diarrhea	Yes	No		Falling	Yes	No		Sexual desire	Yes	No
Joint Pains	Yes	No		Changes in stools	Yes	No		Numbness	Yes	No		Getting erections	Yes	No
Chest Pains	Yes	No		Blood in stools	Yes	No		Weakness	Yes	No		Completing intercourse	Yes	No
Shortness of Breath	Yes	No		Nausea	Yes	No		Appetite	Yes	No				
Hearing	Yes	No		Vomiting	Yes	No		Feeling depressed	Yes	No				
Other concerns to discuss with provider today:														

Have you had any of the following:

Heart disease	Yes	No		High blood pressure	Yes	No
High Cholesterol	Yes	No		Cancer	Yes	No

Previous Surgeries: (Please List) _____

(Examples include: Tonsils, Back, Hernia, Appendix, Gall Bladder, Cervix, Colon, etc.)

Medications: (include non-prescription)

Name of Medication	Strength	How Often		Name of Medication	Strength	How Often

Routine Screenings / Testing : (Please indicate the year in which you last had the following and any abnormalities)

Tetanus Shot _____
Zostavax (shingles) Shot _____
Hepatitis C Lab Screening: _____
Bone Density (DEXA) _____
Flu Shot _____
HPV Shot _____
Eye Exam _____
PSA test _____
Pneumonia Shot _____
Cholesterol Lab Screening: _____
Dental Exam _____
Colonoscopy _____

Social History:

Marital Status: Single Married Separated Divorced Widowed
Use of Alcohol: Never Rarely Moderate Daily Drinks per day: _____
Use of Tobacco: Never Previously, but quit Current Packs per day: _____
Use of Drugs: Never Current Type / Frequency _____
Caffeine: Never Current – type/frequency per day _____
Exercise: Never Current – type / frequency per week _____
Do you have a Living Will or Advance Directives: Yes No

Family Medical History:

	Age	Diseases	If Deceased, Age and Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____