Well Male Exam
Completely Confidential
This information will help us give better health care

Family Practice Centre of Livonia, PC
38253 Ann Arbor Road
Livonia, MI 48150

Name	Age	Date of Birth	Marital Status

PLEASE ANSWER EACH QUESTION AS CORRECTLY AS YOU CAN. PLACE "X" IN PROPER SPACE

	NO	YES NOW	YES PAST
Have you ever had a prostate exam?	____	____	____
Date of last exam _____			
Have you ever had a PSA blood test?	____	____	____
Were the results normal?	____	____	____
Have you ever had an abnormal PSA ?	____	____	____
Do you have any discharge from penis?	____	____	____
Do you perform a self-exam of testicles?	____	____	____
Have you noticed any lumps?	____	____	____
Have you had pain/swelling in testicles?	____	____	____
Are you sexually active ?	____	____	____
Have you had pain during sex?	____	____	____
Partners in last year? ___ Lifetime? ____			
Have you ever had a sexually transmitted disease ?_____	____	____	____
Do you & partner use birth control?	____	____	____
Type _____			
Have you had the following problems?			
High Blood Pressure	____	____	____
Heart Disease	____	____	____
Cancer	____	____	____
High Cholesterol	____	____	____
Do you have the following problems?			
Bothersome joint pains	____	____	____
Change in size / firmness of stools	____	____	____
Change in size / color of a mole	____	____	____
Sleeping poorly or having any trouble falling or staying asleep	____	____	____
Often feeling down, depressed or hopeless	____	____	____
Chest pain, shortness of breath, stomach problems or heartburn	____	____	____
Problems with falling or doing routine tasks at home	____	____	____
Periods of weakness, numbness or inability to talk	____	____	____
Do you smoke cigarettes, cigars, pipes?	____	____	____
Do you chew tobacco?	____	____	____
If past, when did you stop? _____			
How Much ? _____			
How many years? _____			
Do you drink alcohol?	____	____	____
How much per week? _____			
Do you drink coffee, tea or caffeinated Beverages? Cups per day _____	____	____	____
Do you exercise? How often _____	____	____	____
Do you always wear a seat belt?	____	____	____
Have you had a tetanus shot	____	____	____
Date _____			

URINARY ACTIVITY - Circle the best answer

Over the last month or so, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?
0 1 2 3 4 5 or more

Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?
0 1 2 3 4 5 or more

Over the past month or so, how often have you had to urinate again less than two hours after you finished ?
0 1 2 3 4 5 or more

Over the past month or so, how often have you found that you stopped and started again several times when you urinated?
0 1 2 3 4 5 or more

Over the past month or so, how often have you found it difficult to postpone urination?
0 1 2 3 4 5 or more

Over the past month or so, how often have you had a weak urinary stream?
0 1 2 3 4 5 or more

Over the past month or so, how often have you had to push or strain to begin urination?
0 1 2 3 4 5 or more

SEX FUNCTION - Circle the best answer

Decrease in spontaneous early morning erections
1 Rare 2 Mild 3 Frequent 4 Severe

Decreased libido or desire for sex
1 Rare 2 Mild 3 Frequent 4 Severe

Decrease in fullness of erections
1 Rare 2 Mild 3 Frequent 4 Severe

Decrease in volume of ejaculate or semen
1 Rare 2 Mild 3 Frequent 4 Severe

Decrease in strength of climax or force of muscular pulsations
1 Rare 2 Mild 3 Frequent 4 Severe

Decrease in maintaining full erection
1 Rare 2 Mild 3 Frequent 4 Severe

Decrease in starting erection or no erection
1 Rare 2 Mild 3 Frequent 4 Severe

Any other problems doctor should be aware of:

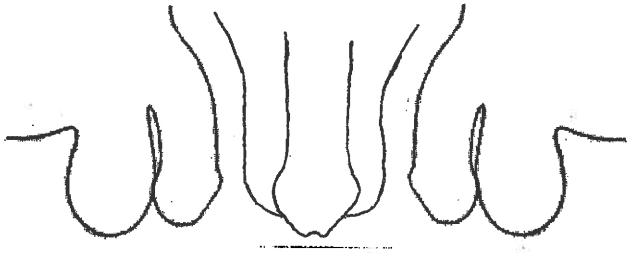
FOR DOCTOR'S USE ONLY

Height _____ inches BP _____ / _____ R or L Temp _____
Weight _____ pounds _____ / _____
B.M.I. _____ Pulse _____ / minute Resp _____

Vision Right _____ / _____ Left _____ / _____ Corrected or Uncorrected
Allergies:

Chief Complaint :

PHYSICAL EXAM



Y or N Palpable Mass / Lump
Y or N Skin Discoloration
Y or N Swelling
Y or N Lesions
Plan:

	Right	Frontal	Left
HEENT	Normal	Abnormal	
Heart	Normal	Abnormal	
Lungs	Normal	Abnormal	
Genitourinary	Normal	Abnormal	
Abdomen	Normal	Abnormal	
Prostate	Normal	Abnormal	
Rectum	Normal	Abnormal	
Skin	Normal	Abnormal	
Extremities	Normal	Abnormal	

Diagnoses:

Plan / Impression

____ Stool Card Given / Returned on _____ Result _____

Past Medical History:

Medications:

Past Surgical History:

ADVISED OF :

	Self Testicle Exam
	Need for Diagnostic Testing Reviewed
	ACS Hemoccult / Colonoscopy
	Yearly Physical

RETURN _____ Days _____ Months _____ Weeks _____ Years

Date _____ _____ R.N./M.A. Date _____ _____
Provider