



Flathead Valley Community College™

Student Health Clinic

Name _____

Date of Birth _____

Well Male Exam Questionnaire

Are you concerned about any of the following? (circle yes or no and specific problem)

- Eating habits: weight gain or loss, sleep habits.....yes no
- Eye redness, pain, increased tearing, drainage, blurred, decreased vision yes no
- Ear pain, decreased hearing yes no
- Heart problems, chest pain, palpitations, blood pressure, leg swellingyes no
- Lung problems, difficulty breathing, wheezing, cough yes no
- Abdominal pain, nausea, vomiting, diarrhea, constipation, bloody stoolyes no
- Kidney or bladder problems, infection, blood in urine yes no
- Joint pain, stiffness, swelling, muscles pain or weakness yes no
- Skin, rash, itching, dryness, hair or nail problemsyes no
- Recurrent headaches, dizziness, numbness, weaknessyes no
- Stress, anxiety, sadness, depression, suicidal thoughts yes no
- Excessive thirst or hunger, increased urination, weight lossyes no
- Paleness, anemia, easy bruising, swollen glands yes no
- Allergies, hay fever, asthma, infections yes no

Comments _____

Personal History

Are you concerned about any of the following? (circle yes or no)

- Penis or testicles.yes no
- Prostate.....yes no
- Erections or intercourse.....yes no
- Sexually transmitted diseases, AIDS, other sexual concernsyes no
- Are you sexually active?yes no

Comments _____

Name _____

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Social History

Are you: single married divorced widowed ?

Do you feel safe at home, in your relationships with family/partner?yes no

Do you smoke or use tobacco products?yes no

If yes, how many packs/cans per day? _____ How many years? _____

Do you use recreational drugs?yes no

If yes, type _____ frequency? _____

Do you drink alcohol?yes no

If yes, how many per day? _____ per week? _____

Do you always use a seat belt in a vehicle?yes no

Preventative Health History

Have you ever had a PSA (prostate) blood test?.....yes no

When? _____ Was it normal?.....yes no

Have you ever had a colonoscopy?yes no

Have you ever had your cholesterol checked?.....yes no

When? _____ Was it normal?yes no

Have you had a tetanus shot in the past 10 years?..... yes no

When? _____

Personal/Family History

Have **you** had any of the following?

Prostate Cancer yes no when? _____

Colon Cancer yes no when? _____

Osteoporosis yes no when? _____

Heart disease yes no when? _____

Heart attack before age 55 yes no when? _____

Have any **close relatives** had any of the following?

Prostate Cancer yes no who? _____

Osteoporosis yes no who? _____

Heart Disease yes no who? _____

Heart attack before the age of 55 yes no who? _____

Do you have any concerns you wish to discuss? _____

Patient signature _____ **Date** _____