The Physicians Center For Wellbeing
1140 S Linden Road
Flint, Michigan 48532
Phone: 810 732-3180
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Well-Male Exam

Name: _____ **Age:** _____ **Date:** _____

Vital Signs: HT _____ **WT** _____ **BP** _____/_____ **ALL** _____ **Meds Rev: No change Refills**

Smoker ➔ Amount: _____

Are you sexually active? Yes No
If yes, do you and your partner use birth control? Yes No
Method: _____
Have you ever had a sexually transmitted disease? Yes No

Is there any family history of?

Breast cancer?	Yes No	Osteoporosis?	Yes No
Colon cancer?	Yes No	Heart disease?	Yes No
Uterine cancer?	Yes No	Heart attacks?	Yes No
Ovarian cancer?	Yes No	Other cancer?	Yes No
Prostate cancer?	Yes No	Type: _____	

Is conflict in your family or relationships sometimes handled by pushing, hitting or cruelty? Yes No

Have you ever used tobacco? Yes No If yes:
Average number of packs per day: _____
Number of years smoked: _____
Year quit: _____
Are you planning to quit?
Now Next time Sometime Never

Do you drink alcohol? Yes No
If yes, have you ever:
Felt you should cut down on your drinking? Yes No
Been annoyed by people nagging about the drinking? Yes, No
Felt guilty about your drinking? Yes No
Had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No

Prevention:
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

Exercise:
Activity: _____

Days per week: _____

Time/duration: _____
Exertion: stroll mild heavy

Do you always wear seatbelts? Yes No
If over 30 years old, have you had your cholesterol level checked in the past five years? Yes No
Have you had a tetanus shot in the past 10 years? Yes No
Does your house have a working smoke detector? Yes No
Do you have firearms at home? Yes No

Do you have any of the below:

Change in frequency of urination	Y	N
Urinating more than once a night	Y	N
Change in your urine stream	Y	N
Change in erections	Y	N

When was your last:
Dental check up? _____Eye Exam
Stress test_____ Colonoscopy_____
PSA_____

Please list any other concerns:

_____

_____

_____

Provider's initials: _____
Revision date: 4-30-2015

The Physicians Center for WellBeing

REVIEW OF SYSTEMS

Board Certified Family Practice
1140 S Linden Rd
Flint, Michigan 48532

NAME:_____ **AGE:** _____ **DATE:** _____

Do you have…….Check (x) either yes or no	Yes	No	**Check (x) either yes or no**	Yes	No
GENERAL:			**GU:**		
Normal activity/energy level			Penile discharge (Male only)		
Change in appetite			Frequent urination during the night		
Major weight gain			Difficulty with urination		
Major weight loss			Pain with urination		
Feel uneasy/out of sorts			Blood in urine		
Chills			Difficulty with urine stream strength or flow		
Fever					
Sweating			**MUSCULOSKELETAL:**		
			Muscle or joint pain		
			Weakness		
EYES:			Swelling		
Vision changes			Inflammation		
Double vision			Restriction of motion		
			Loss of muscle		
EARS/NOSE/MOUTH/THROAT:			Backache		
Buzzing/ringing in ears					
Hearing loss			**NEUROLOGICAL:**		
Gum bleeding			Weakness		
Nosebleeds			Dizziness		
Hoarseness			Loss of consciousness		
Difficulty swallowing			Stroke/TIA/Numbness		
Sinus congestion			Seizures		
Sinus pain			**Headaches**		
			SKIN/BREAST:		
RESPIRATORY:			Rashes		
Recent upper respiratory infections			Non-healing lesions		
Shortness of breath			Breast problems		
Cough			Change in size or color of mole		
Coughing or spitting up blood					
Wheezing			**PSYCHIATRIC:**		
			Increased nervousness		
			Mood changes		
CARDIAC:			Coping well		
Chest pain			Trouble falling or staying asleep		
Palpitations					
Difficulty breathing when lying down			**ENDOCRINE:**		
Shortness of breath with activity			Thyroid problems		
Sudden shortness of breath sleeping			Heat or cold intolerance		
			Diabetes		
			Excessive thirst or hunger		
GI:			Excessive urination		
Any food intolerance					
Abdominal pain			**HEMATOLOGIC/LYMPHATIC:**		
Nausea			Anemia		
Vomiting			Easy bruising		
Bloating			Bleeding		
Heartburn/indigestion			Swollen nodes		
Diarrhea					
Constipation			**ALLERGIC/IMMUNOLOGIC:**		
Black or tarry stools			Hay fever		
Blood in stools			History of environmental allergies		
Change in bowel consistency			Chronic problems with immunity		