Wetaskiwin Family Medical Practice

Please complete prior to appointment.

MALE

Name: ___________________________

1. Have you had any of the following problems:

High Blood Pressure **YES** **NO**

Heart Disease **YES** **NO**

Cancer **YES** **NO**

High Cholesterol **YES** **NO**

Abdominal or pelvic surgery or special tests **YES** **NO**

2. Do you have any of the following:

a. Bothersome joint pain **YES** **NO**

b. Sexual problems (getting and keeping erections, completing intercourse, etc.) **YES** **NO**

c. Change in size/firmness of stools **YES** **NO**

d. Sleeping poorly or having any trouble falling or staying asleep during the past month **YES** **NO**

e. Change in size or color of a mole **YES** **NO**

f. Difficulty with urine stream strength or flow rate **YES** **NO**

g. Getting up frequently at night to urinate **YES** **NO**

h. Severe headaches **YES** **NO**

i. Chest pain, shortness of breath, stomach problems or heartburn **YES** **NO**

j. Problems with falling or doing routine tasks at home **YES** **NO**

k. Often feeling down, depressed or hopeless during the past month **YES** **NO**

l. Often having little interest or pleasure in doing things during the past month **YES** **NO**

m. Periods of weakness, numbness or inability to talk **YES** **NO**

n. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty **YES** **NO**

3. Have you had or 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**

c. Diabetes **YES** **NO**

If yes to a, b or c:
Relation: __________________ Type: _______________
Relation: __________________ Type: _______________
Relation: __________________ Type: _______________
Relation: __________________ Type: _______________

4. Have you ever used tobacco? **YES** **NO**
If yes:
Average number of packs/day:_____
Number of years smoked:______
Year quit:_____
When or are you planning to quit?
now **next 6 months** **sometime** **never**

5. Do you drink alcohol? **YES** **NO**
How many drinks per week? ____________________
Type of Alcohol? _____________________________
If yes:
a. Have you ever felt you should cut down on your drinking? **YES** **NO**

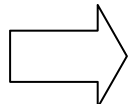
b. Have people ever annoyed you by nagging you about your drinking? **YES** **NO**

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**

6. Do you use street drugs? **YES** **NO**

Please complete other side



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7. Prevention:

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

Grains and starches	**Many**	**Some**	**Few**
Vegetables	**Many**	**Some**	**Few**
Dairy foods	**Many**	**Some**	**Few**
Meats	**Many**	**Some**	**Few**
Sweets	**Many**	**Some**	**Few**

b. Exercise: ___________________________________

Activities: __________________________________

____

Days per week: _____________

Time/duration: ________ minutes

Exertion: **Stroll** **Mild** **Heavy**

c. Have you had a tetanus shot in the past 10 years? **YES** **NO**

d. Do you see a dentist regularly? **YES** **NO**

e. Do you get an influenza shot yearly? **YES** **NO**

12. If you have medical concerns, please list the 3 most urgent: ____

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