

PHYSICAL EXAM - MALE

Patient Name: _____ Date of Birth: _____ Date of Exam: _____

Allergies: Are you allergic to any medicines? Circle one: Yes No If yes, please complete the following:
Medication Type of Reaction

Medications: Please list current medicines, inhalers, over the counter medicines, vitamins, and herbals:

<u>Medication</u>	<u>Dose</u>	<u>How often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Operations/Hospital Stays: Please list ALL operations and overnight hospital stays (not ER visits):

Operation/Stay: _____ Date: _____

Operation/Stay: _____ Date: _____

Social History:

Do you smoke? Yes No If yes, how much per day? _____ for how many years? _____
 Have you ever smoked? Yes No Quit Date _____
 Do you drink alcohol? Yes No If yes, how often? _____ how much? _____
 Do you take illicit drugs ("street drugs")? Yes No If yes, which drug? _____
 Do you drink caffeinated beverages? Yes No If yes, how often? _____ how much? _____
 Describe your eating habits: _____
 Describe your exercise routine: _____
 What is your sexual preference? Male Female Bisexual

Family History: Please answer the following questions about your family's health:

Diabetes	Yes No	If yes, who? _____	High blood pressure	Yes No	If yes, who? _____
Asthma	Yes No	If yes, who? _____	High cholesterol	Yes No	If yes, who? _____
Heart issues	Yes No	If yes, who? _____	Heart Attack	Yes No	If yes, who? _____
Stroke	Yes No	If yes, who? _____	Depression/Anxiety	Yes No	If yes, who? _____
Cancer	Yes No	If yes, who and what type? _____			

Medical History: Have you ever been diagnosed with or are currently having any of the following symptoms? Please circle all that apply, and when this was an issue for you (date).

HEENT:

Headache
 Ear problems
 Nose/sinus problems
 Throat problems

Musculoskeletal:

Back problems
 Joint Pain
 Arthritis
 Broken bones
 Osteoporosis

Endocrine:

Diabetes
 Thyroid problems
 Tired/sluggish
 Excessive thirst

Skin:

Hives
 Eczema
 Psoriasis
 Allergic Rash

Gastrointestinal:

Abdominal Pain
 Constipation
 Diarrhea
 Colitis
 Diverticulitis
 Heartburn/reflux
 Ulcers
 Hemorrhoids
 Change in Bowel Habits

Genitourinary/GYN:

Bladder infections
 Kidney stones
 Prostate infections
 Ovary problems
 Uterine problems
 Abnormal Pap smear
 Breast lump

Cardiac:

Chest Pain (Angina)
 Heart Attack
 High Blood Pressure
 High Cholesterol
 Heart Racing
 Palpitations
 Heart Failure
 Pacemaker
 Heart Valve
 Rheumatic Fever

Blood/Immune:

Anemia
 Blood clot
 Jaundice
 Lupus
 Liver disease

Neurologic:

Seizures/epilepsy
 Stroke
 Loss of strength
 Loss of sensation
 Numbness/tingling
 Multiple Sclerosis

Respiratory:

Asthma
 COPD
 Emphysema
 Bronchitis
 Pneumonia
 Pulmonary embolism

Psychologic:

Anxiety
 Depression
 Bipolar disease
 Panic attacks