

# MALE PATIENT HEALTH CHECK

TODAY'S DATE: \_\_\_\_\_

FULL NAME: \_\_\_\_\_ | DATE OF BIRTH: \_\_\_\_\_ | AGE: \_\_\_\_\_

Please mark 'X' where necessary for the following symptoms:	YES	NO
<b>NERVOUS SYSTEM:</b>		
Hearing loss		
Vision Change		
Headache		
Fits/Faints		
Limb Weakness		
Limb Numbness		
Speech Change		
Incoordination		
<b>CARDIOVASCULAR SYSTEM:</b>		
Chest pain		
Shortness of breath		
Ankle swelling		
Palpitations		
Calf pain when walking		
Difficulty breathing at night or laying down		
<b>GASTRIC SYMPTOMS:</b>		
Indigestion		
Difficulty swallowing		
Vomiting		
Blood in vomit		
Weight loss		
<b>BOWEL SYMPTOMS:</b>		
Change bowel habit		
Loss of appetite		
Abdominal pain		
Blood from rectum or in bowel motions		



Please mark 'X' where necessary for the following symptoms:	YES	NO
<b>RESPIRATORY SYMPTOMS:</b>		
Cough		
Phlegm		
Coughing up blood		
Wheeze		
<b>UROLOGICAL SYMPTOMS:</b>		
Increase urine frequency		
Urinating at night		
Urge to pass urine often		
Incontinence		
Dribbling		
Sexual dysfunction		
Concern about sexual health		
<b>MOOD SYMPTOMS:</b>		
Poor sleep		
Lack of enjoyment		
Anxiousness		
Depressed		
Irritability		
Poor concentration		

*Please also complete the following section found on the next page. If you have a problem answering any questions on this form bring this up in consultation with your Doctor today.*

## MALE PATIENT HEALTH CHECK

<b>Significant Medical History:</b>			
<b>Family History of Health Problems:</b>			
<b>Average Alcohol Weekly Intake:</b>			
<b>Please circle your Smoking Status:</b>	Never Smoked	Ex Smoker	Currently Smoke
<b>Allergies/Adverse Reactions to Medication:</b>			
<b>List of Current Medications:</b>			