# MALE PATIENT HEALTH CHECK

TODAY'S DATE: _____

FULL NAME: _____ | DATE OF BIRTH: _____ | AGE: _____

| *Please mark 'X' where necessary for the following symptoms:* | YES | NO |
|---|---|---|
| **NERVOUS SYSTEM:** | | |
| Hearing loss | ☐ | ☐ |
| Vision Change | ☐ | ☐ |
| Headache | ☐ | ☐ |
| Fits/Faints | ☐ | ☐ |
| Limb Weakness | ☐ | ☐ |
| Limb Numbness | ☐ | ☐ |
| Speech Change | ☐ | ☐ |
| Incoordination | ☐ | ☐ |
| **CARDIOVASCULAR SYSTEM:** | | |
| Chest pain | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| Ankle swelling | ☐ | ☐ |
| Palpitations | ☐ | ☐ |
| Calf pain when walking | ☐ | ☐ |
| Difficulty breathing at night or laying down | ☐ | ☐ |
| **GASTRIC SYMPTOMS:** | | |
| Indigestion | ☐ | ☐ |
| Difficulty swallowing | ☐ | ☐ |
| Vomiting | ☐ | ☐ |
| Blood in vomit | ☐ | ☐ |
| Weight loss | ☐ | ☐ |
| **BOWEL SYMPTOMS:** | | |
| 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 |
|---|---|---|
| **RESPIRATORY SYMPTOMS:** | | |
| Cough | ☐ | ☐ |
| Phlegm | ☐ | ☐ |
| Coughing up blood | ☐ | ☐ |
| Wheeze | ☐ | ☐ |
| **UROLOGICAL SYMPTOMS:** | | |
| Increase urine frequency | ☐ | ☐ |
| Urinating at night | ☐ | ☐ |
| Urge to pass urine often | ☐ | ☐ |
| Incontinence | ☐ | ☐ |
| Dribbling | ☐ | ☐ |
| Sexual dysfunction | ☐ | ☐ |
| Concern about sexual health | ☐ | ☐ |
| **MOOD SYMPTOMS:** | | |
| 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

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

**Please print as a PDF and send as an attachment to:- forms.showgrounds@guardianmedical.com.au**