Annual Questionnaire for Men

If you are uncomfortable with any question, please feel free to leave it blank.

Date:_____ **Name**_____

Blood pressure:_____/_____ **Pulse:** _____ **Weight:**_____ **Height:**_____

What concerns are you hoping to discuss at your annual visit?

_____

_____

_____

What new medical problems, medicines or medicine allergies have you had since your last visit?

_____

_____

Have you seen other doctors or been to the Emergency room this year?

_____

Are you concerned that your medicines are making you ill? Yes No Maybe N/A
Are you confident in managing your health problems? Yes No Maybe N/A

Your exercise habits:

What do you do for exercise?
_____
How often?_____
For how much time?_____
Any troubles when exercising? *please circle*
chest pain, dizziness, fainting,
shortness of breath,
other pain or injuries
Are you working to change your weight? Yes No
If yes, how:_____

Your diet:

How many servings do you get each day of
____High calcium food
____Fruit
____Vegetables
____High fiber carbohydrate
Do you eat breakfast? _____

Other habits that protect your health:

Do you wear your seatbelt?..... Yes No
Do you have working smoke detectors?..... Yes No
Do you wear sunscreen?..... Yes No N/A
Do you use hearing protection around loud noises?..... Yes No N/A
Do you brush and floss your teeth daily?..... Yes No N/A
Have you had a dental cleaning in the last year?..... Yes No N/A
Do you have grab bars in the bath and handrails on stairs? Yes No
Do you have well lit and cleared pathways in your home? Yes No
If you keep guns are they secured and unloaded?..... Yes No N/A

Potential Health Hazards:

How much caffeine do you use daily? _____
Do you smoke or chew tobacco? ____ If yes, how much? _____
If so, do you plan to quit? _____ When? _____
Do you consume alcohol?_____ If yes, how much?_____
Do you feel you should cut down? Yes No N/A
Have others recommended you cut down? Yes No N/A
Do you ever drink before driving? Yes No N/A
Do you use any other drugs like marijuana, crack/cocaine, narcotics, heroin, MDMA, others?

Date:_____ **Name**_____

Men's sexual health

Are you having troubles with sex: pain, change in desire, difficulty with erections or other issues? _____

How many sexual partners have you had in the last year: none one male 2-5 female more than 5? both?

What do you do so your female partner doesn't get pregnant: please circle
no sex, menopause, hoping to get pregnant, condoms, vasectomy, tubal, pills, patch , ring, IUD, fertility awareness, pulling out, diaphragm, spermicide, hysterectomy, infertility?

Have you ever had a sexually transmitted disease? Yes No

Do you use condoms to protect yourself from sexually transmitted diseases? Yes No N/A

Have you had any of these problems: *please circle all that apply*

Blood in urine
Trouble with urine leaking
Slowed urine stream or dribbling
Unexplained frequent urination
Increase in night time urination
Change in bowel habits
Blood in stool
Trouble with your memory
Any falls
Head aches
Vision problems
Trouble hearing
Difficulty sleeping
Trouble swallowing
Cough
Shortness of breath
Chest pains
Swelling of hands or feet
Leg pain when you walk up stairs or hills
Hoarseness
New or changed moles or other skin changes
Unexplained lump
Unexplained weight loss
Unexplained bruising or bleeding
Fatigue
Unexplained thirst
Snoring
Spells of weakness, inability to speak or face drooping
Pain that interferes with your ability to do your every day activities
Trouble doing your daily activities: cooking, laundry, housework, using the phone, managing money, managing medicines, driving, other:

Mental Health:

Have you been feeling down, depressed or hopeless?	Yes	No
Have you felt little interest in doing things?	Yes	No
Are you often anxious?	Yes	No
Is someone at home abusing alcohol or drugs?	Yes	No
Do you feel unsafe in your home?	Yes	No
Are you threatened, pushed or hit?	Yes	No
Do you threaten, push or hit others?	Yes	No
Are you having trouble solving family conflicts?	Yes	No
Are you having troubles at work?	Yes	No
Is your work damaging your health?	Yes	No
Do you have a lot of stress in your life?	Yes	No

How do you relieve stress? _____
_____

Does stress, anxiety or depression interfere with you ability to do everyday activities?_____

Do you have a Living Will, Advanced Directives or a Health Care Proxy?_____