ASHLAND FAMILY HEALTH CARE, P. C.
420 Williamson Way Ashland, Oregon 97520
514-488-3616

MALE QUESTIONNAIRE

Name_____**DOB**_____**Chart #**_____

To help your doctor during today's health exam, please complete items 1 through 8.

1. Age: _____

2. Have you had any of the following problems:

☐ High blood pressure
☐ Heart disease
☐ Cancer
☐ High cholesterol
☐ List any other medical problems_____

3. Do you currently have any of the following problems:

☐ Bothersome joint pains
☐ Sexual problems (getting and keeping erections, completing intercourse, etc.)
☐ Change in size/firmness of stools
☐ Change in size/color of a mole
☐ Sleeping poorly or having any trouble falling or staying
☐ asleep during the past month
☐ Often feeling down, depressed or hopeless during the past month
☐ Often having little interest or pleasure in doing things during the past month
☐ Difficulty with urine stream strength or flow rate
☐ Getting up frequently at night to urinate
☐ Chest pain or shortness of breath
☐ Stomach problems or heartburn
☐ Problems with falling or unable to do routine tasks at home
☐ Periods of weakness, numbness or inability to talk

4. Do you have a parent, grandparent, brother or sister with a history of the following:

	Relation
☐ Cancer of _____	_____
☐ Heart problems or heart attacks	_____
☐ Asthma or emphysema	_____
☐ Diabetes	_____
☐ High Blood Pressure	_____
☐ Stroke	_____
☐ Other	_____

5. Are you a current smoker? _____Yes _____No
Average number of packs/day: _____
When are you planning to quit?
(Circle) now / next 6 months / sometime / never

Have you used tobacco in the past? ____Yes ____No
If yes:
Number of years smoked: _____
Year quit: _____

6. Do you drink alcohol? ____Yes _____No
If yes:
How much? _____drinks per day / week / month /year
(Circle)

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

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

Grains and starches	____a lot	____ some	____few
Vegetables	____a lot	____ some	____few
Dairy foods	____a lot	____ some	____few
Meats	____a lot	____ some	____few
Sweets	____a lot	____ some	____few

b. Exercise:
Activity _____
Days per week _____
Time/duration _____ minutes

c. Do you always wear seat belts? ____Yes _____No

d. If over 30 years old, have you ____Yes _____No had your cholesterol level checked in the past five years?

e. Have you had a tetanus shot in the past 10 years? ____Yes _____No

f. Does your house have a working smoke detector? ____Yes _____No

g. Do you have firearms at home? ____Yes _____No

h. How many sexual partners have you had in the last 12 months? ____ In your lifetime? ____

i. When is the last time you had a dental check-up?_____

8. Please describe any concerns you have:
_____
_____
_____
_____
_____
_____
_____

Thank you for your help.