FLINT
FAMILY HEALTHCARE
4 N. MAIN STREET
MAYSVILLE, GA 30558

Well Checkup - Male: 18 and up

Patient Name:

_____DOB:_____Appt. Date: _____

Please answer each question below.

When was your last physical? ☐ Unsure ☐ Date: _____	When was your last vision exam? ☐ Unsure ☐ Date: _____
When was your last dental exam? ☐ Unsure ☐ Date: _____	When was your last tetanus shot? ☐ Unsure ☐ Date: _____
When was your last bone density test? ☐ Unsure ☐ Date: _____	When was your last colonoscopy? ☐ Unsure ☐ Date: _____
When was your PSA last checked? ☐ Unsure ☐ Date: _____	When was your last prostate exam? ☐ Unsure ☐ Date: _____
List providers you have seen since your last visit.	
Current Health Concerns:	
Would you like any STD testing to be completed today? ☐ Yes ☐ No	

Male Health Assessment

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none."

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Sweating (night sweats or excessive sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night, or waking up too early)	☐	☐	☐	☐	☐
Increased need for sleep or falls asleep easily after a meal	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, and getting angry easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina, or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire or in sexual performance)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain and swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places, or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches/migraines	☐	☐	☐	☐	☐
Rapid hair loss or thinning	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain, increased belly fat, or difficulty losing weight, despite diet and exercise	☐	☐	☐	☐	
Infrequent or absent ejaculations	☐	☐	☐	☐	☐
Total Score:					
Severity Score: Mild: 1-20 / Moderate: 21-40 / Severe: 40-60 / Very severe: 61-80					