



Longs Peak Family Practice: Male Medical History Assessment/Update

Name _____ Date of Birth _____ Date _____

1. Please list any new medical problems since your last physical examination here.

2. Please list any medical concerns you wish to address at this visit.

3. Have you seen a specialist or other healthcare provider since your last visit? YES/NO If yes, who did you see and what for? (Please sign a Release of Information form at the front desk)

Over the past two weeks, how often have you:

4. Felt little interest or pleasure in doing things (circle one)

0: Not at all 1: several days 2: more than half the days 3: nearly every day

5. Felt down, depressed, or hopeless (circle one)

0: Not at all 1: several days 2: more than half the days 3: nearly every day

6. Are you sexually active? YES/NO

7. Are you currently sexually active with more than one partner? YES/NO

(Circle one): Male/ Female/ Both/ N/A

8. Would you like STD/STI screening today? YES/NO

9. When was your last prostate exam? _____ What was your last PSA? _____

10. Have you ever had an abnormal prostate exam? YES/NO

11. Have you noticed any swelling/enlargement of your testicles? YES/NO

12. Are you having difficulty urinating? YES/NO

13. Do you have any blood in your urine? YES/NO

14. Are you having difficulty with erections? YES/NO

15. Have you had your stool tested for blood in the last year? YES/NO

16. Do you take baby aspirin daily? YES/NO

17. Have you ever had a colonoscopy? YES/NO If yes, when and what were the results?

18. Have you ever had any rectal bleeding? YES/NO

19. Have you ever had an exercise treadmill or other heart test performed? YES/NO

If yes, when and what type of test? _____

20. Please list any **NEW** medical problems in your relatives since your last exam:

Father: _____

Mother: _____

Siblings: _____

Children: _____