



**ANDOVER**  
**FAMILY**  
**MEDICINE**

**Well Adult Exam-Male**

Name \_\_\_\_\_ Age \_\_\_\_\_

Regular Exercise : no \_\_\_ yes \_\_\_

Family/Personal history of colon cancer or other gastric cancer : no \_\_\_ yes \_\_\_

Have you had a colonoscopy : no \_\_\_ yes \_\_\_ Year \_\_\_\_\_

Family/Personal history of prostate cancer : no \_\_\_ yes \_\_\_

Family history of ovarian, endometrial, or breast cancer : no \_\_\_ yes \_\_\_

Have you had cholesterol screening : no \_\_\_ yes \_\_\_ Year \_\_\_\_\_

Have you had diabetes screening : no \_\_\_ yes \_\_\_ Year \_\_\_\_\_

Tetanus vaccine : Year \_\_\_\_\_

Pneumonia vaccine (if over 65) : no \_\_\_ yes \_\_\_ Year \_\_\_\_\_

Shingles vaccine (if over 50) : no \_\_\_ yes \_\_\_ Year \_\_\_\_\_

Do you take a multivitamin daily : no \_\_\_ yes \_\_\_

Do you take an aspirin daily : no \_\_\_ yes \_\_\_

Tobacco use : no \_\_\_ yes \_\_\_ If yes, how many years have you smoked? \_\_\_\_\_

How many packs per day? \_\_\_\_\_

If no, have you smoked in the past? \_\_\_\_\_

If you are over 55 and have a history of smoking,  
when was your last CT lung scan? \_\_\_\_\_

Alcohol Use : no \_\_\_ yes \_\_\_ Do you have more than 8 drinks per week? \_\_\_\_\_