



Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### Well Adult Exam-Male

Regular Exercise: No \_\_\_ Yes \_\_\_

Family/Personal history of prostate cancer: No \_\_\_ Yes \_\_\_

Family history of ovarian, endometrial, or breast cancer: No \_\_\_ Yes \_\_\_

Family/Personal history of colon cancer, pancreatic, or other gastric cancer: No \_\_\_ Yes \_\_\_

Have you had a screening colonoscopy (if over age 45): No \_\_\_ Yes \_\_\_ Year \_\_\_\_\_

Have you had cholesterol screening: No \_\_\_ Yes \_\_\_ Year \_\_\_\_\_

Have you had diabetes screening: No \_\_\_ Yes \_\_\_ Year \_\_\_\_\_

Year of last Tetanus vaccine: \_\_\_\_\_ Annual Flu vaccine: No \_\_\_ Yes \_\_\_

Gardasil vaccine series completed: No \_\_\_ Yes \_\_\_

Pneumonia vaccine (age 50+): No \_\_\_ Yes \_\_\_

COVID-19 vaccine: No \_\_\_ Yes \_\_\_

Shingles vaccine (age 50+): No \_\_\_ Yes \_\_\_

Do you take a multivitamin daily: No \_\_\_ Yes \_\_\_

Do you take an aspirin daily: No \_\_\_ Yes \_\_\_

Do you have family history of aortic aneurysm? No \_\_\_ Yes \_\_\_

Have you ever smoked or used chewing tobacco: No \_\_\_ Yes \_\_\_

If **yes**, how many years have you/did you smoke? \_\_\_\_\_

If you quit, at what age did you quit? \_\_\_\_\_

If you are over 50 and have a 20-pack year history of smoking, when was your last CT lung cancer screening? Year \_\_\_\_\_

Alcohol Use: No \_\_\_ Yes \_\_\_ Do you have more than 8 drinks per week? \_\_\_\_\_

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**Name:** \_\_\_\_\_

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Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things?

- Not at all
- Several days
- More than half the days
- Nearly every day

2. Feeling down, depressed, or hopeless?

- Not at all
- Several days
- More than half the days
- Nearly every day

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