

WELL MAN QUESTIONNAIRE

NAME: _____

Date _____

Family Planning

Are you sexually active? YES NO
What do you use for birth control? _____

How many partners have you had? _____

Have you ever had an STD? _____

If yes, what kind? _____

Prostate/Rectal Exam History

Have you ever had an abnormal rectal or prostate
exam? YES NO

If yes, what was the date? _____

For the problem was these performed?

Biopsies: YES NO

Surgery: YES NO

What was the result? _____

Have you ever had a colonoscopy? YES NO

If yes, what was the date? _____

What were the results? Abnormal Normal

Pelvic/Abdominal Surgeries

Have you ever had abdominal surgeries? YES NO

If yes, what was the date? _____

What was the purpose? _____

Past Medical History

Please circle if YOU have now or have ever had any
of these medical conditions:

High Blood Pressure Heart Disease Anemia

High Cholesterol Migraine Asthma Arthritis

Blood Clots (where _____) Depression

Cancer (what kind? _____) Diabetes Anxiety

Skin Disorder (what kind? _____) Allergies

Lung Disease (COPD Emphysema Asthma)

Family History

Do you have a parent or sibling with a history of
colon, prostate or rectal cancer or heart disease
or depression? YES NO

If yes, who was it and what did they have? _____

Prevention History

Do you eat a well-balanced diet that is also low
in sugar and fats? YES NO

Do you exercise regularly? YES NO

How many days a week? _____

How long do you exercise for? _____

What kind of exercise? _____

When was your last Tetanus shot? _____

When was your last Flu shot? _____

When was your last EKG? _____

Have you ever had a chest xray? YES NO

If yes, when? _____

Review of Systems

Please circle below anything that you have experienced CHRONICALLY or RECENTLY. (The provider may ask for you to return for another office visit to adequately address any complicated issues)

General: fever chills fatigue general weakness

Eyes: visual disturbances eye irritation

Ears, Nose & Throat: runny nose sore throat nosebleeds ear pain trouble hearing

Heart: chest pain chest palpitation difficulty breathing on exertion passing out

Lungs: trouble breathing coughing spitting up phlegm wheezing

Breast: lumps skin changes drainage from the nipple

Abdomen: abdominal pain diarrhea constipation nausea vomiting

Urinary: urinating more than usual burning when urinating trouble holding urine retaining urine

Rectal: rectal bleeding black stools constipation change in firmness of stools

Genitals: vaginal discharge vaginal irritation irregular periods pain during intercourse

Skin: rash moles that have recently appeared or changed in size or color

Neuro: headaches numbness or tingling weakness in one body part dizziness speech problems

Musculoskeletal: joint pain joint swelling neck pain joint deformity

Psych: trouble sleeping conflict in family or personal relationships that is sometimes handled by pushing/hitting/cruelty
feeling depressed feeling anxious thoughts of hurting yourself/anyone else