MALE REVIEW OF SYMPTOMS

NAME: ______________________________ DATE: __________

Please circle **ONLY** if applicable.

HEENT

Vision problems

Vision change

Glaucoma

Ear problems

Impaired hearing

Dizziness

Ringing

Sinus problems

Nose bleeds

Mouth or teeth problems

Gum disease

Difficulty swallowing

Frequent sore throats

Sore tongue

Mass of neck

Swollen glands

CARDIOVASCULAR/ RESPIRATORY

Chest pain

Chest pressure/discomfort

Angina

Heart trouble

Heart murmur

Lightheadedness

Palpitations

Leg cramps

Swelling

Paroxysmal nocturnal dyspnea (PND)

Claudication

GASTROINTESTINAL

Abdominal pain

Nausea

Vomiting

Heartburn

Change in stool

Change in stool consistency

Change in bowel habits

Losing control of bowels

Constipation

Diarrhea

Excessive belching

Excessive flatulence

Blood in stool

BM daily

RESPIRATORY

Difficulty breathing

Wheezing

Chest congestion

Cough

Phlegm

Spitting blood

Shortness of breath on exertion

Shortness of breath when lying down

GENITOURINARY

Losing control of urine

Urinary urgency

Night-time urination

Frequent urination

Difficulty urinating

Burning of pain on urination

Reduced stream

Dribbling

Blood in urine

Genital sores

Testicular pain

Testicular problems

Testicular masses

Penile pain

Penile discharge

Erectile dysfunction

Performs regular testicular exam

Pelvic pain

Lumps/growths

Itching

Has your sex drive decreased lately?

Do you have problems with impotence?

Do you have any problems getting an erection?

Is your erection less hard?

Do you have difficulty in maintaining an erection?

Do you have difficulty with penetration?

Do you have less early morning erections?

Do you have cold sweats?

Do you perspire other than times when you exercise?

Do you feel very warm at times?

INTEGUMENTARY

Bruising

Dry skin

Hives

Itching

Skin lumps/mass

Mole changes

Sores

Rash

Hair changes

Nail changes

Varicose veins

Phlebitis

NEUROLOGICAL

Headaches

Migraines

Seizures

Fainting

Lightheadedness

Dizziness upon standing

Vertigo

Ringing in the ears

Short term memory problems

Confusion/disorientation

Localized weakness

Numbness/tingling

Muscle weakness

Involuntary movements

Trouble with coordination

Difficulty walking

Loss of limb use

Tremors

Balance problems

Losing control of urine or bowel

Loss of muscle bulk

MUSCULOSKELETAL

Limited join mobility

Joint pain

Muscle pain

Stiffness

Tenderness

Muscle weakness

Neck pain

Back pain

Difficulty walking

Trouble reaching above head

Deep leg pain

Cold hands and feet

PSYCHIATRIC

Anxiety

Nervousness

Irritability

Depression

Sadness

Frequent crying

Memory loss

Sleep problems

Hallucinations

Suicidal thoughts

Homicidal thoughts

Stress

ENDOCRINE

Excessive appetite

Excessive sweating

Excessive thirst

Excessive urination

Heat intolerance

Cold intolerance

Hair loss

Excess hair growth

HEMATOLOGIC/ LYMPHATIC

Easy bleeding or bruising

Anemia

Swollen glands

ALLERGIC/IMMUNOLOGIC

Latex allergy

Environmental allergies

Immunodeficiency

Autoimmune disorder

QUESTIONNAIRE 1

Do you exercise?

Do you eat three meals a day?

Do you sleep an average of 6-8 hours?

Do you enjoy your work?

Do you watch more than 2 hours of TV a day?

Do you take vacations?