MEN'S HEALTH CHECK QUESTIONNAIRE

DATE: _____

FULL NAME: _____ | DATE OF BIRTH: _____ |

Please tick where necessary for the following symptoms:	YES	NO
CARDIOVASCULAR SYSTEM:		
Chest pain		
Shortness of breath		
Ankle swelling		
Palpitations		
Calf pain when walking		
Difficulty breathing at night or laying down		
RESPIRATORY SYMPTOMS:		
Cough		
Phlegm		
Coughing up blood		
Wheeze		
GASTRIC SYMPTOMS:		
Indigestion		
Difficulty swallowing		
Vomiting		
Blood in vomit		
Weight loss		
BOWEL SYMPTOMS:		
Change bowel habit		
Loss of appetite		
Abdominal pain		
Blood from rectum or in bowel motions		
Date of last bowel screen/colonoscopy (if applicable)		

Please tick where necessary for the following symptoms:	YES	NO
UROLOGICAL SYMPTOMS:		
Increase urine frequency		
Urinating at night		
Urge to pass urine often		
Incontinence		
Dribbling		
Sexual dysfunction		
Concern about sexual health/erectile dysfunction		
MOOD SYMPTOMS:		
Poor sleep		
Lack of enjoyment		
Anxiousness		
Depressed		
Irritability		
Poor concentration		
Memory Loss		
NERVOUS SYSTEM:		
Hearing loss		
Vision Change		
Headache		
Fits/Faints		
Limb Weakness		
Limb Numbness		
Speech Change		
Incoordination		

Please also complete the following section found on the next page. If you have a problem answering any questions on this form bring this up in consultation with your Doctor today.

Significant Medical History:				
Family History of Health Problems:				
Average Alcohol Weekly Intake:	Beer	Spirits	Wine	
Please circle your Smoking and recreational drugs usage status	Never Smoked	Ex Smoker	Currently Smoke	Recreational Drugs
Allergies/Adverse Reactions to Medication:				

Please tick where necessary for the following symptoms:	YES	NO
MISCELLANEOUS:		
Previous mole mapping		
Any skin lesions of concern today?		
Do you see any Specialist doctors?		
Do you see any Allied Health Professionals? – Podiatrist/Physio etc		
Do you feel you are up to date with vaccinations?		

Please tick where necessary for the following symptoms:	YES	NO
MISCELLANEOUS:		
Are you a carer for someone?		
Do you want a medication review?		
Have you had a previous Bone density scan?		
Have you been to an Optometrist recently (12 months)		

Patient Signature: _____ Date:_____.

Please print as a PDF and send as an attachment to admin@ofpmildura.au