The Medical Centre

Whitehall, Galway, H91 D9FW
Telephone: (091) 564241 **Fax:** (091) 566020
Email: whitehallmedicalcentre.gp@healthmail.ie

WELL MAN QUESTIONNAIRE

Name: _____

Address: _____

_____

Email: _____

Date of Birth / /

To assist our GP during your upcoming Well Man Health Review, please complete the questions below.

General Lifestyle Questions:

1. Do you smoke? Yes ___ No____ Have previously _____
2. If yes or previously, how many do (did) you smoke per day? _____
3. How often do you drink alcohol? Never ____ Daily _____ 1-2 times_____
4. How may standard drinks to you consume each week? (1 standard drink = half pint Beer or 1 glass wine 100ml or 1 pub measure of spirits 35.5ml) _____
5. Do you take illicit substances eg. Cannabis, Cocaine? Yes _____ No _____
6. How often do you exercise?
   Daily _____ 1-2 times per week _____ 3-4 times per week _____
   Weekly _____ Monthly _____
7. What type of exercise to you take?
   Walking _____ Running _____ Golf _____ Gym _____ Other _____
8. How may portions of fruit/vegetables do you eat per day?
   0 ___ 1 ___ 2-3 ____ 3-4 _____ 4-5 _____ More than 5 _____
9. How many portions of sweets, cakes, chocolate, and biscuits do you eat per day?
10. 0 ___ 1 ___ 2-3 ____ 3-4 _____ 4-5 _____ More than 5 _____
11. Do you feel stressed? Yes _____ No _____

12. Have you ever suffered from? (please tick relevant boxes)

a. Chest pain _____

b. Shortness of breath _____

c. Palpitations _____

d. Cough _____

e. Abdominal pain _____

f. Change in bowel habit _____

g. Problems passing urine _____

h. Blood when you go to the toilet _____

i. Headaches _____

j. Joint pains, neck or back pain _____

k. Difficulty sleeping _____

l. Difficulty concentrating, low mood or feeling anxious _____

m. Unexplained weight loss _____

n. Night Sweats _____

13. **Have you ever suffered from? (Please tick the relevant boxes)**

a. Heart attack of Angina Yes _____ No _____

b. Rheumatic Fever Yes _____ No _____

C . High Blood Pressure Yes _____ No _____

D. High Cholesterol Yes _____ No _____

E. Asthma Yes _____ No _____

F. Bronchitis / Emphysema Yes _____ No _____

G. Cancer (please specify type) Yes _____ No _____

H. Thyroid Disorder Yes _____ No _____

I. Allergies Yes _____ No _____

J. Migraine Yes _____ No _____

K. Blackouts / Seizures Yes _____ No _____

L. Stroke / Mini Stroke Yes _____ No _____

M. Back Pain Yes _____ No _____

N. Depression Yes _____ No _____

O. Anxiety Yes _____ No _____

P. Osteoporosis Yes _____ No _____

Q. Diabetes Yes _____ No _____

14. If you have a family history of any of the conditions above, please provide details below

_____

_____

_____

15. Have you ever been hospitalised in the past or had any operations, please provide details below: _____

_____

_____

16. List the current medications you're on:

_____

_____

_____

_____

Male Wellbeing:

Do you regularly examine your testicles? Yes _____ No _____

Have you ever had any lumps or swelling in your testicles? Yes _____ No _____

Do you get up at night to pass urine on a regular basis? Yes _____ No _____

If yes, how many times a night? _____

Have you noticed any change in the flow, rate or stream of your urine? Yes _____ No _____

Do you ever have a prostate examination / PSA (prostate) blood test? Yes _____ No _____

Do you have pain on passing urine? Yes _____ No _____

Do you ever have blood in your urine? Yes _____ No _____

Would you like to discuss anything related to sexual health? Yes _____ No _____

General Health:

Is there any other aspect of your health that you would like to discuss? Yes _____ No _____

If yes, please provide details below

_____

_____

_____

Please bring completed form with you to your appointment.