VALLEY OB-GYN CLINIC

MALE EXAM

Pt. Name _____ Birthday _____ Age _____ Date _____

LOWEST

HISTORY OF PRESENT ILLNESS

Est New/Cons	1: chief 1-3	2: 1-3 1-3	3: 1-3 4+	4: 4+ 4+	5: 4+ 4+

❍ Location ❍ Modifying Factors ❍ Duration ❍ Associated Sign/SX ❍ Severity ❍ Quality ❍ Timing ❍ Context

REVIEW OF SYSTEMS

Est New/Cons	1:	2: Pert.	3: Pert. 2-9	4: 2-9 10+	5: 10+ 10+

❍ Constitutional	❍ Neurological	❍ Psychiatric	❍ Eyes	❍ ENT, Mouth	❍ Hematologic/Lymph	❍ Endocrine
❍ Integumentary	❍ Cardiovascular	❍ Respiratory	❍ Allergies/Immun.	❍ Musculoskeletal	❍ Gastrointestinal	❍ Genitourinary

Above checked systems were reviewed on pt. history dated _____ . Additional Comments: _____

PAST MEDICAL, FAMILY, SOCIAL HISTORY

Est New/Cons	3: 1-2	4: 1 3	5: 2-3 3

Medical, family, and social history reveiwed on pt. history dated _____ . Additional history includes:

PHYSICAL EXAM

Est New/Cons	1: 1+	2: 1+ 6+	3: 6+ 12+	4: 12+ All 1ea.	5: All 1 ea. All 1 ea.

1. Vitals (3 required) BP _____ Ht _____ Wt _____ P _____ R _____

2. General Appearance

	Nml.	Abn.	Comments		Nml.	Abn.
3. Neurological				8. Lymphatic		
4. Psychiatric				9. Skin		
5. Eyes				10. Cardiovascular		
6. ENT. Mouth				11. Lungs/Chest		
7. Neck				12. Musculoskeletal		
13. Chest				20. Seminal Vesicles		
14. Scrotum				21. Sphincter Tone		
15. Epididymides				22. Anus & Perineum		
16. Testes				23. Abdom./Bladder/Kidney		
17. Urethral Meatus				24. Liver and/or Spleen		
18. Penis				25. Hernia ____Absent		
19. Prostate				26. Stool Speciman ___ Not Need ___ Coll.		

DX 3: 2 Self Limit or 1 est. worsening
4: 1 New w/o workup or 1 self/est worsening
5: 1 New w/workup or both items in DX4

IMPRESSION

Risk 3: OTC Drug; Minor w/o risk
4: Rx; Minor w/ risk; Major w/o risk
5: Controlled; Major w/ risk; Emer. major

PLAN

☐ Stool/Sigmoid Eval. ____
☐ Labs _____
☐ Other _____

Handouts (H) and or Counseling (C)

GENERAL HEALTH

H	C	
☐	☐	Smoking (AP065)
☐	☐	Cholesterol (AP101)
☐	☐	
☐	☐	

SURGICAL PROCEDURE

H	C	
☐	☐	VASECTOMY (K1516)

_____ Other _____

Rx: _____

Follow Up: _____

Provider Date

11/05