**Identification Number: __________________ Date of Birth: ______________ Zip Code: ____________**

**How did you hear about this event? ______________________________________________________________**

<table>
<thead>
<tr>
<th><strong>Demographic Information</strong></th>
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<tbody>
<tr>
<td><strong>Race:</strong> (please check the one you most identify with)</td>
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<tr>
<td>☐ Black/African American</td>
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<tr>
<td>☐ American Indian/Alaska Native</td>
</tr>
<tr>
<td>☐ Asian</td>
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<tr>
<td><strong>Ethnicity:</strong> Do you identify as Hispanic or Latino?</td>
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</table>
### Medical History

**Do you have a medical doctor/healthcare provider you regularly see?**
- [ ] Yes
- [ ] No

**When was the last time you were seen by a medical doctor/healthcare provider?**
- [ ] 0-1 Year
- [ ] 1-5 Years
- [ ] > 5 Years
   - If not every year, please tell us why ___________________

**When do you normally see your doctor/healthcare provider?**
- [ ] Only when I'm having a problem
- [ ] Routinely, even if I'm feeling well
- [ ] Never

**How often do you think a man should see a doctor/healthcare provider if he's feeling well?**
- [ ] Never
- [ ] Every 3 months
- [ ] Every 6 months
- [ ] Every 1 year
- [ ] Other ______________

**Have you or a family member ever been treated for the following?**
- Heart Disease
  - [ ] Myself
  - [ ] Family Member
- Heart Attack
  - [ ] Myself
  - [ ] Family Member
- High Blood Pressure
  - [ ] Myself
  - [ ] Family Member
- Stroke
  - [ ] Myself
  - [ ] Family Member
- Diabetes - Insulin
  - [ ] Myself
  - [ ] Family Member
- Diabetes - Non Insulin
  - [ ] Myself
  - [ ] Family Member
- Arthritis
  - [ ] Myself
  - [ ] Family Member
- Colorectal Polyps
  - [ ] Myself
  - [ ] Family Member
- Prostate Cancer
  - [ ] Myself
  - [ ] Family Member
- Alcohol-Related Problems
  - [ ] Myself
  - [ ] Family Member
- Depression
  - [ ] Myself
  - [ ] Family Member
- Anxiety Disorder
  - [ ] Myself
  - [ ] Family Member
- COPD or Asthma
  - [ ] Myself
  - [ ] Family Member
- Other Cancer ______________
  - [ ] Myself
  - [ ] Family Member

**In general...**

**Are you taking any prescription medication?**
- [ ] Yes
- [ ] No

**Are you taking any over-the-counter supplements?**
- [ ] Yes
- [ ] No

**Do you experience pain on a daily basis?**
- [ ] Yes
- [ ] No

**Do you take over-the-counter pain medication on a daily basis?**
- [ ] Yes
- [ ] No

**Do you take prescription pain medicine on a daily basis?**
- [ ] Yes
- [ ] No

**Do you have any problems urinating?**
- [ ] Yes
- [ ] No

**Do you take medication to decrease the times you wake to urinate at night?**
- [ ] Yes
- [ ] No

**How would you rate your sexual desire (libido)?**
- [ ] High
- [ ] Low
- [ ] Normal

**How often do you have sex?**
- [ ] Daily
- [ ] Weekly
- [ ] Monthly
- [ ] A few times a year
- [ ] Not sexually active

**Do you take medication for erections (Viagra, Levitra, or Cialis) or use injections, pumps?**
- [ ] Yes
- [ ] No

**In general, would you say your health is:**
- [ ] Very Good
- [ ] Fair
- [ ] Poor

**Do you see yourself as:**
- [ ] Underweight
- [ ] Normal Weight
- [ ] Overweight
- [ ] Obese

**Does your current health limit your daily activities?** (for example, climbing stairs, vacuuming, or bowling)
- [ ] Yes, limited a lot
- [ ] Yes, limited a little
- [ ] No, not limited at all

**Compared to one year ago, how would you rate your health in general now?**
- [ ] Better
- [ ] Same
- [ ] Worse
Has your doctor/healthcare provider talked to you about screening for testicular cancer?  
- Yes
- No

Do you perform testicular self-exams?  
- No
- Yes, about once a year
- Yes, every month

Do you think you would recognize testicular cancer if you had it?  
- Yes
- No

### Lifestyle

#### Caffeine:
- (coffee, soda, energy drinks, etc.)
  - None
  - 2 cups or less per day
  - More than 2 cups per day

#### Alcohol intake:
- None
- 2 drinks or less per day
- More than 2 drinks per day

#### Tobacco:
- Do you currently use tobacco?  
  - Yes
  - No
  - Number of packs per day ______
- Do you use E-cigarettes or vape?  
  - Yes
  - No
- If not using tobacco now, any past use?  
  - Yes
  - No

#### Are you homeless?  
- Yes
- No

#### Drugs:
- Do you use marijuana?  
  - Yes
  - No
- Do you use street drugs?  
  - Yes
  - No

#### Do you have a smartphone?  
- Yes
- No

#### Diet:
- Do you consume red meat more than 3 times per week?  
  - Yes
  - No
- Do you consume "Fast Food" more than 3 times per week?  
  - Yes
  - No
- Do you eat more than 3 servings of fruits and vegetables per day?  
  - Yes
  - No

#### Exercise:
- Do you lift weights more than 3 times per week?  
  - Yes
  - No
- Do you run, walk, bike or swim more than 3 times per week?  
  - Yes
  - No
- What is the longest you sit per day, at any one given time?  
  - More than 3 hours
  - Less than 3 hours

#### Religion and Spirituality:
- Are you spiritual or religious?  
  - Yes
  - No
- Do you pray or meditate?  
  - Yes
  - No

#### Sleep:
- How many hours of sleep do you get per night on average?  
  - More than 8
  - 6-8
  - Less than 6
- How many times do you wake per night to urinate?  
  - Zero
  - 1 time
  - 2 or more times
- When you wake in the morning, do you feel rested?  
  - Yes
  - No
- What is the quality of your sleep?  
  - Good
  - Poor

#### Food Security:
- Within the past 12 months, have you worried that food for your family would run out before you got money to buy more?  
  - Often True
  - Sometimes True
  - Never True
- Does some or all of your food come from a food assistance program (bridge card, food bank, shelter, etc.)?  
  - Yes
  - No
How would you rate your average level of stress during the past month?

*Little or no stress -->* 1 2 3 4 5 6 7 8 9 10 *A great deal of stress*

Have you experienced any of the following in the last year: Marriage, divorce, death of someone close to you, job change or loss, move, financial difficulty, medical issue, or legal issue? □ Yes □ No

Thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the **past 30 days** was your mental health **not** good?

Thinking about your physical health, which includes physical illness and injury, for how many days during the **past 30 days** was your physical health **not** good?

<table>
<thead>
<tr>
<th>During the past 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than Half of the Days</th>
<th>Nearly Everyday</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2 Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3 Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4 Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5 Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6 Feeling bad about yourself - or that you're a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7 Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8 Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9 Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

10 If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

Thank you for completing this survey. All answers will be kept strictly confidential!