PHYSICAL QUESTIONNAIRE MALE

Patient Name:	**DOB:**	**Date:**

Do you exercise ☐Yes ☐ No **How many times a week** **Do you take vitamins** ☐ Yes ☐No
Have you had a colonoscopy ☐ Yes ☐ No **Date:** **Where:**
Date of your last PSA exam: **Date your last PSA blood test:**
Are you eating : ☐well balanced meals ☐low fat food choices ☐low sodium foods ☐unhealthy meals ☐frequent junk food
How many hours of sleep do you get each night **Has your recent health been** ☐ Good ☐ Fair ☐ Poor
Do you/ or have you ever smoked or used tobacco ☐ Yes ☐ No **How many packs/cans a day** **How long since you quit?**
Are you sexually active ☐ Yes ☐ No **Do you have a decreased libido** ☐Yes ☐No
Surgeries/ Procedures since your last visit here in our office?
Other Concerns: