PHYSICAL QUESTIONNAIRE MALE

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

Do you exercise ☐Yes ☐ No **How many times a week** **Do you take vitamins** ☐ Yes ☐No
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 sex drive** ☐Yes ☐No
Depression: 1. Little to no pleasure in doing things:
☐ **0 =** Not at all ☐ **1 =** Several days ☐ **2 =** More than half the days ☐ **3 =** Nearly everyday
Depression: 2. Feeling down, depressed, or hopeless:
☐ **0 =** Not at all ☐ **1 =** Several days ☐ **2 =** More than half the days ☐ **3 =** Nearly everyday
Alcohol: How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more time a week
How many standard drinks containing alcohol do you have on a typical day?
☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
Surgeries/ Procedures since your last visit here in our office?
Other Concerns:

OFFICE STAFF ONLY

Colonoscopy ☐ Yes ☐ No	**Date:**	**Where:**
Date of Last prostate exam:		**Where:**
Date of last PSA blood test:		**Where:**