



# Adult Male Physical Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Are there any new problems, concerns, or recent surgeries since last physical? \_\_\_\_\_

Please list all medications: \_\_\_\_\_

**Please note:** If you have filled out this form before you may answer only those questions whose answer has changed during the interim.

**Yes No - TOBACCO -**

\_\_\_ \_\_\_ Do you smoke or chew? Packs per day? \_\_\_\_\_ How long? \_\_\_\_\_  
\_\_\_ \_\_\_ Ever quit? \_\_\_\_\_ Want to quit? \_\_\_\_\_

**- EXERCISE -**

\_\_\_ \_\_\_ Do you exercise regularly?  
If so: Some | Moderate | Athletic | Elite Athlete

**- SLEEP -**

\_\_\_ \_\_\_ Do you have problems going to sleep?  
\_\_\_ \_\_\_ Do you have problems staying asleep?  
\_\_\_ \_\_\_ Do you snore?  
\_\_\_ \_\_\_ Have you ever been told you stop breathing while asleep?  
\_\_\_ \_\_\_ Do you have daytime drowsiness?

**- DIET -**

\_\_\_ \_\_\_ Do you eat vegetables daily?  
\_\_\_ \_\_\_ Do you eat red meat regularly?  
\_\_\_ \_\_\_ Do you eat fried foods regularly?  
\_\_\_ \_\_\_ Do you add salt to your foods regularly?  
\_\_\_ \_\_\_ Do you drink or eat milk products regularly?  
\_\_\_ \_\_\_ Do you ever eat in secret or feel bad or guilty about eating?

**- CAFFEINE -**

\_\_\_ \_\_\_ Do you drink caffeinated drinks?  
If so what and how many cups or cans per day? \_\_\_\_\_

**Yes**   **No**

**- ALCOHOL -**

- Do you drink? Frequently | Occasionally | Rarely | Drinks per day? \_\_\_\_\_
- Have you ever felt the need to cut down?
- Have you ever felt annoyed by criticism of drinking?
- Have you every felt guilty about drinking?
- Have you ever taken an "eye opener"?

**- NON-PRESCRIPTION DRUGS -**

- Do you use over-the-counter medications or vitamins?  
If so please include these in your medication list above.
- Have you used anything other than alcohol to get high?  
If so what and when last used? \_\_\_\_\_

**- BOWEL or BLADDER PROBLEMS -**

- Are you having any bowel problems?  
Constipation \ Diarrhea \ Hemorrhoids \ Bleeding \ Other
- Have you ever had a colon exam (i.e., flexible sigmoidoscopy or colonoscopy)?  
If so when and where? \_\_\_\_\_
- Are you having any difficulties with urination?  
Starting | Stopping | Dribbling | Weaker Stream
- Do you get up in the night to urinate? If so how many times at night? \_\_\_\_\_
- Have you had any injuries, infections or surgeries involving your genitalia?  
If so what and when? \_\_\_\_\_
- Do you know how to exam your testicles?
- Have you ever had a rectal exam?  
If so when was your last exam? \_\_\_\_\_

**- SEXUAL HISTORY -**

- Are you having any sexual difficulties that you would like to discuss?
- Do you have any difficulties maintaining or obtaining an erection?
- Do you have any questions or concerns about contraception?

**- EXPOSURE RISK -**

- Have you ever been exposed to any of the following materials or substances.  
- Asbestos - Mineral Dusts - Benzene/Toluene - Chlorinated Solvents -  
- Petroleum - Fuels - Fumes - Lead - Arsenic - Cadmium - Mercury -  
- Radiation - PCB's - Insecticides - Other Exposures  
Please circle and please note when, where and how significantly: \_\_\_\_\_

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- If exposed to any of the above, have you been evaluated for this before?  
If so when and where? \_\_\_\_\_

**Yes**   **No**

**- IMMUNZATIONS & INFECTIONS -**

- Have you received an MMR update? If so when and where? \_\_\_\_\_
- Have you received the Hepatitis B Vaccine Series? If so when and where? \_\_\_\_\_
- Have you received a Tetanus shot in the last 10 years? If so when and where? \_\_\_\_\_
- Have you had Chickenpox or the Varicella Vaccine? If unsure, would you like to be tested? \_\_\_\_\_
- Have you ever been tested for Hepatitis C? Would you like to be tested? \_\_\_\_\_
- Have you ever been tested for HIV? Would you like to be tested? \_\_\_\_\_
- Have you received a Pneumovax? Would like to receive one? \_\_\_\_\_
- Do you get annual Flu Vaccines?

**- MOOD and MEMORY HISTORY -**

Over the last two weeks, have you:

- Felt sad, depressed or hopeless?
- Felt unusually anxious or over-whelmed by your emotions?
- Noticed that others might think you are depressed or sad?
- Had changes in your sleep or appetite?
- Lost interest in previously enjoyable activities?
- Felt withdrawn or distanced from your friends or family?
- Had difficulty remembering events, names or conversations?
- Had difficulty with concentration or staying on task?

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