

Male Wellness Exam

Patient Information

Name:

Date of Birth:

Date of Exam:

Physician/Healthcare Provider:

Medical History

Current Medications:

Past Medical History:

Family Medical History:

Allergies (if any):

Lifestyle Assessment

Diet:

Exercise:

Tobacco Use: Yes No

Alcohol Consumption: Yes No

Stress Levels: Low Moderate High

Physical Examination

Height:

Weight:

BMI:

Blood Pressure:

Pulse:

Respiratory Rate:

General Appearance:

Heart Examination:

Lung Examination:

Abdominal Examination:

Screening Tests

Cholesterol Levels:

Blood Glucose Levels:

Prostate-Specific Antigen (PSA) Test: Yes No

Testicular Exam: Yes No

Skin Cancer Screening: Yes No

Colorectal Cancer Screening: Yes No

Other Relevant Screenings:

Laboratory Tests

Complete Blood Count (CBC):

Liver Function Tests:

Kidney Function Tests:

Thyroid Function Tests:

Mental Health Screening

Depression Screening: Yes No

Anxiety Screening: Yes No

Other Mental Health Concerns:

Discussion and Recommendations

Physician's Notes:

Lifestyle Recommendations:

Follow-up Appointments:

Referrals (if any):

Patient Acknowledgment

Patient's Signature:

Date:

Physician/Healthcare Provider's Signature

Name:

Date: