# Male Wellness Exam

| Patient Information |
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| 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: |

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| 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: |
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| Lifestyle Recommendations: |
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| Follow-up Appointments: |
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| Referrals (if any): |
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| **Patient Acknowledgment** |
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| Patient's Signature: |
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| Date: |
| **Physician/Healthcare Provider's Signature** |
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| Name: |
| Date: |