# Male Physical Exam

## PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Contact information: _____ Date of exam: _____ dd / mm / yyyy

## MEDICAL HISTORY REVIEW

Past medical history:

Surgical history:

Current medications:

Allergies:

Family medical history:

Social history (tobacco, alcohol, recreational drug use):

Diet & exercise:

Vaccination status:

## VITAL SIGNS

Blood pressure:

Heart rate:

Respiratory rate:

Temperature:

Height:

Weight:

Body mass index (BMI):

## GENERAL PHYSICAL EXAMINATION

General appearance:

- [ ] Alert
- [ ] Oriented
- [ ] Distress level
- [ ] Hygiene

**HEENT:**

- [ ] Head shape
- [ ] Pupils
- [ ] Conjunction
- [ ] Ears
- [ ] Nose
- [ ] Throat

**Neck:**

- [ ] Thyroid size
- [ ] Lymphadenopathy
- [ ] Neck mobility

**Cardiovascular:**

- [ ] Heart sounds
- [ ] Rhythm
- [ ] Murmurs

**Respiratory:**

- [ ] Breath sounds
- [ ] Symmetry
- [ ] Wheezes/rales

**Abdomen:**

- [ ] Palpation
- [ ] Bowel sounds
- [ ] Tenderness
- [ ] Organomegaly

**Musculoskeletal:**

- [ ] Range of motion
- [ ] Joint tenderness
- [ ] Gait

**Neurological:**

- [ ] Reflexes
- [ ] Sensation
- [ ] Coordination
- [ ] Mental status

## SKIN AND NAILS

**Rashes:**

**Lesions:**

**Discoloration:**

**Nail abnormalities:**

## MALE-SPECIFIC ASSESSMENTS

Testicular exam:

◯ Masses ◯ Tenderness ◯ Swelling

**Hernia exam:**

Penis exam:

◯ Lesions ◯ Discharge ◯ Signs of STIs

**Prostate exam (if indicated):**

## LABORATORY AND SCREENING

**Blood tests:**

**a. Complete Blood count (CBC):**

**b. Lipid profile:**

**c. Blood glucose:**

d. Thyroid function (TSH, if applicable):

Urinalysis:

Prostate-specific antigen (PSA) (if over 50 or at risk):

Abdominal aortic aneurysm (AAA) screening (if 65–75 and history of smoking):

Vision and hearing screen:

## MENTAL HEALTH SCREENING

Mood assessment:

Anxiety/depression indicators:

Stress levels:

Cognitive concerns:

## PREVENTIVE COUNSELING

Nutrition and weight management:

Physical activity:

Smoking/tobacco cessation:

Alcohol use guidance:

STI prevention and safe practices:

Immunizations review (Influenza, Tdap, HPV, Shingles, etc.):

Diet & exercise:

Age-appropriate screenings (colorectal, prostate, etc.):

## ADDITIONAL NOTES

Specify below:

## HEALTHCARE PROFESSIONAL INFORMATION

Name: _____ License ID number: _____

Signature:

Date of exam: _____ dd / mm / yyyy