

MALE HORMONE SCREENING

Date: _____

Name: _____

Address: _____

Phone: _____

Date of Birth: _____ Height: _____ Weight: _____

Rate the following as they apply to you. **Use the numbers 1-4, with 1 being Rare or Mild, and 4 being Frequent or Severe.**

	Rare	Mild	Frequent	Severe
1. Fatigue, tiredness or loss of energy	1	2	3	4
2. Decrease in physical stamina	1	2	3	4
3. Feelings of depression - a sense that work, marriage or recreational activities have lost significance	1	2	3	4
4. Decreased libido - less desire for sex	1	2	3	4
5. Erection or potency problems	1	2	3	4
6. Loss of early morning erection	1	2	3	4
7. Dry skin on face or hands	1	2	3	4
8. Increase in waist size - weight gain, especially around mid-section	1	2	3	4
9. Increased fat distribution in chest area or hips	1	2	3	4
10. Feeling burned out, loss of motivation	1	2	3	4
11. Increase in aches, joint and muscle pains	1	2	3	4
12. Frequent use of alcohol - now or in the past	1	2	3	4
13. Increased irritability, anger or bad temper	1	2	3	4
14. Decrease in muscle mass	1	2	3	4
15. The age your are:____ The age you feel:____				

What prescription and/or non-prescription drugs are you taking (include vitamins, herbal products, or other supplements)? _____

What medical conditions are you being treated for? _____

What medical conditions have you been treated for in the past 5 years? _____
