

Men's Hormone Questionnaire

Name _____ Age _____ Today's Date _____

Please List any Medications or supplements you are taking:

Please list you main symptoms and concerns:

What are your goals for therapy?

1. _____

2. _____

3. _____

Symptom	Absent	Mild	Moderate	Severe
Burned out feelings				
Decreased mental sharpness				
Nervous				
Decreased stamina				
Decreased flexibility				
Elevated triglycerides or cholesterol				
Headaches				
Decreased urine flow				
Bone loss				
Swollen or puffy eyes				

Brittle or breaking nails				
Rapid heartbeat				
Low blood sugar				
Oily skin or hair				
Apathy				
Depression				
Anxious				
Decreased muscle size				
Neck or back pain				
Sugar craving				
Decreased erections				
Increased urinary urge				
Stress				
Slow pulse				
Thinning skin				
High blood pressure				
Acne				
Difficulty sleeping				
Mental fatigue				
Morning Fatigue				
Sore Muscles				
Weight gain				
Heart palpitations				
Cold body temperature				
Decreased libido				
Rapid aging				
Low blood pressure				

Increased forgetfulness				
Irritable				
Evening fatigue				
Joint pain				
Prostate Problems				
Dry or brittle hair				
Constipation				

Please describe any other symptoms not listed.

Have you been diagnosed with Prostate or Testicular cancer? _____

Do you initiate intercourse? _____

Is intercourse satisfying? _____

Do you achieve orgasm? _____

Do you suffer from premature ejaculation? _____

How often do you have intercourse? _____

Is your sex drive the same as it was five years ago? _____

Please list any other sexual dysfunctions or problems. _____

Have you gained or lost weight in the last two years? Describe

Have you fathered any children? How many? _____

Sexual Orientation? Heterosexual___ Homosexual___ Bisexual___

Have you previously used hormones or steroids either prescribed or unprescribed?

Are there any other symptoms or problems you wish to discuss or are the other issues I should be aware of?
