

MALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, anger easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (poor recovery after workout, inability to add muscle, joint pain, muscle weakness)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Sexual Desire or Performance (reduced or diminished)	☐	☐	☐	☐	☐
Erectile changes (weaker erections, loss of morning erections)	☐	☐	☐	☐	☐
Ejaculations (infrequent or absent)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hair loss, rapid or thinning	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

PATIENT INFORMATION

NAME: _____ TODAYS DATE: _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

PATIENT QUESTIONS

CURRENTLY TRYING TO CONCEIVE? ☐ YES ☐ NO

ARE YOU ON A 5-ALPHA REDUCTASE INHIBITOR? ☐ YES ☐ NO

ARE YOU ON A PDE-5 INHIBITOR (CIALIS, VIAGRA, ETC.) ☐ YES ☐ NO

ARE YOU ON ANY OTHER TESTOSTERONE BOOSTING MEDICATION (CLOMID, HCG, ETC.)? ☐ YES ☐ NO

ARE YOU CURRENTLY UTILIZING BHRT OR HRT? ☐ YES ☐ NO

IF SO, TYPE/S OF HORMONES: ☐ TESTOSTERONE ☐ THYROID

BRAND & DOSE OF HORMONES: _____

ARE YOU CURRENTLY ON STATINS? ☐ YES ☐ NO

ARE YOU A SMOKER? ☐ YES ☐ NO

ARE YOU CURRENTLY ON ORAL NITRATES? ☐ YES ☐ NO

MEDICAL HISTORY

SELECT ALL THAT APPLY

FERTILITY:

☐ WANT TO MAINTAIN FERTILITY

CARDIOVASCULAR CONDITIONS:

☐ HEART ATTACK OR STROKE (WITHIN LAST 6 MONTHS)

☐ TACHYCARDIA

☐ DVT OR BLOOD CLOT (WITHIN LAST 6 MONTHS)

☐ HYPERTENSION

☐ HYPERLIPIDEMIA

☐ OBSTRUCTIVE SLEEP APNEA

☐ ATRIAL FIBRILLATION

☐ TAKING ANTICOAGULANT MEDICATION

ENDOCRINE & METABOLIC:

☐ DIABETES TYPE 2 OR INSULIN RESISTANCE

☐ HYPERTHYROID

☐ HYPOTHYROID

☐ MULTIPLE ENDOCRINE NEOPLASIA TYPE 2

CANCER:

☐ BREAST CANCER OR HISTORY OF BREAST CANCER

☐ ACTIVE PROSTATE CANCER OR HISTORY OF
PROSTATE CANCER?

☐ THYROID CANCER OR HISTORY OF THYROID CANCER

☐ BASAL CELL CARCINOMA

☐ OTHER: _____

NEUROLOGICAL CONDITIONS:

☐ EPILEPSY OR SEIZURE DISORDER

☐ DEPRESSION OR ANXIETY

☐ PSYCHIATRIC CONDITIONS

☐ MIGRAINE WITH AURA

☐ MENINGIOMA

MEDICAL HISTORY

SELECT ALL THAT APPLY

AUTOIMMUNE CONDITIONS:

- ☐ DIABETES TYPE 1
- ☐ HASHIMOTO'S THYROIDITIS
- ☐ GRAVES' DISEASE
- ☐ RHEUMATOID ARTHRITIS
- ☐ MULTIPLE SCLEROSIS
- ☐ SYSTEMIC LUPUS (ERYTHEMATOSUS)
- ☐ PSORIASIS
- ☐ IRRITABLE BOWEL SYNDROME (IBS)
- ☐ CROHN'S DISEASE
- ☐ ULCERATIVE COLITIS

ORGAN SPECIFIC CONDITIONS:

- ☐ LIVER DISEASE OR HISTORY OF LIVER DISEASE
- ☐ KIDNEY DISEASE OR HISTORY OF KIDNEY DISEASE
- ☐ LAM (LYMPHANGIOLEIOMYOMATOSIS)
- ☐ OSTEOPOROSIS OR OSTEOPENIA
- ☐ HIV
- ☐ HEPATITIS
- ☐ HEMOCHROMATOSIS
- ☐ PANCREATITIS OR HISTORY OF PANCREATITIS
- ☐ GALL BLADDER DISEASE, OR HISTORY OF DISEASE
- ☐ POLYCYTHEMIA VERA (PV)

SYMPTOMS & CONCERNS

SELECT ALL THAT APPLY

- ☐ ACNE
- ☐ ERECTILE DYSFUNCTION (ED)
- ☐ DECREASED LIBIDO
- ☐ DECREASED DESIRE
- ☐ DELAYED ORGASM, OR INABILITY TO
- ☐ WEIGHT GAIN
- ☐ DECREASED MUSCLE MASS
- ☐ DIFFICULTY SLEEPING
- ☐ URINARY INCONTINENCE
- ☐ DRY OR FLAKING SKIN
- ☐ LACK OF ENERGY (FATIGUE)
- ☐ DECREASE IN STRENGTH OR ENDURANCE

- ☐ DECREASE IN WORK PERFORMANCE
- ☐ FREQUENT URINARY TRACT INFECTION (UTI)
- ☐ BRITTLE NAILS
- ☐ THINNING EYEBROWS
- ☐ HAIR THINNING
- ☐ COLD HANDS OR FEET
- ☐ MIND RACING AT BEDTIME
- ☐ EATING WHEN STRESSED
- ☐ MOOD SWINGS
- ☐ GYNECOMASTIA (ENLARGED BREASTS)
- ☐ ABDOMINAL OBESITY