**Male Symptoms Checklist**

Place an “X” for EACH symptom you are currently experiencing. *Please mark only* ***ONE*** *box.*

For symptoms that do not apply, please mark 0.

**LEAST MOST**

 0 1 2 3 4

1. **Decline in your feeling of general well-being** ☐ ☐ ☐ ☐ ☐

(general state of health, subjective feeling)

1. **Joint pain and muscular ache** (lower back pain, joint pain, ☐ ☐ ☐ ☐ ☐

pain in a limb, general back ache)

1. **Excessive sweating** (unexpected/sudden episodes of sweating, ☐ ☐ ☐ ☐ ☐

hot flushes independent of strain)

1. **Sleep problems** (difficulty falling asleep, difficulty sleeping through the night, ☐ ☐ ☐ ☐ ☐

waking up early and feeling tired, poor sleep, sleeplessness)

1. **Feeling confident/ability to handle stress** ☐ ☐ ☐ ☐ ☐
2. **Irritability** (feeling aggressive, easily upset about little things, moody) ☐ ☐ ☐ ☐ ☐
3. **Anxiety/Nervousness** (inner restlessness, feeling panicky) ☐ ☐ ☐ ☐ ☐
4. **Physical exhaustion / lacking vitality** (general Changes in performance, ☐ ☐ ☐ ☐ ☐

reduced activity, lack of interest in leisure activities, getting less done,

achieving less, having to force oneself to undertake activities)

1. **Changes in muscular strength** (weakness, tiredness) Weaker ☐ ☐ ☐ ☐ Stronger ☐
2. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, ☐ ☐ ☐ ☐ ☐

mood swings, feeling nothing is of any use)

1. **Feeling that you have passed your peak** ☐ ☐ ☐ ☐ ☐
2. **Do you have cold hands and/or feet?** ☐ ☐ ☐ ☐ ☐
3. **Changes in hair thickness or color** ☐ ☐ ☐ ☐ ☐
4. **Changes in ability/frequency to perform sexually** ☐ ☐ ☐ ☐ ☐
5. **Changes in the number of morning erections** ☐ ☐ ☐ ☐ ☐
6. **Changes in sexual desire/libido** (lacking pleasure in sex, ☐ ☐ ☐ ☐ ☐

lacking desire for sexual intercourse)

**Please share any additional comments about your symptoms you would like to address**. \_

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 **Total \_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many times per week do you engage in moderate physical activity? 🡺** *Physical activity that increases heart rate / breathing*

☐ 0-1 day per week ☐ 2-3 days per week ☐ More than 3 days per week

**Please check any prior hormone therapy:**

☐ Testosterone: Creams, gel, injections, pellets, pills ☐ DHEA ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Recent PSA level:** ☐ **Recent Digital Rectal Exam (Date): \_\_\_\_\_\_** ☐ **Normal /** ☐ **Abnormal**

**History of Prostate problems or Biopsy. If so, please provide details.**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_