



Name: _____ Date: _____

Place an "X" for EACH symptom you are currently experiencing. **Please mark only ONE box.**
For symptoms that do not apply, please mark **NONE**.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1. Decline in your feeling of general well-being (general state of health, subjective feeling)		<input type="checkbox"/>				
2. Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)		<input type="checkbox"/>				
3. Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)		<input type="checkbox"/>				
4. Sleep problems (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)		<input type="checkbox"/>				
5. Increased need for sleep, often feeling tired		<input type="checkbox"/>				
6. Irritability (feeling aggressive, easily upset about little things, moody)		<input type="checkbox"/>				
7. Nervousness (inner tension, restlessness, feeling fidgety)		<input type="checkbox"/>				
8. Anxiety (feeling panicky)		<input type="checkbox"/>				
9. Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)		<input type="checkbox"/>				
10. Decrease in muscular strength (feeling of weakness)		<input type="checkbox"/>				
11. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)		<input type="checkbox"/>				
12. Feeling that you have passed your peak		<input type="checkbox"/>				
13. Feeling burnt out, having hit rock-bottom		<input type="checkbox"/>				
14. Decrease in beard growth		<input type="checkbox"/>				
15. Decrease in ability/frequency to perform sexually		<input type="checkbox"/>				
16. Decrease in the number of morning erections		<input type="checkbox"/>				
17. Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)		<input type="checkbox"/>				

Please share any additional comments about your symptoms you would like to address. _____

Do you have cold hands and feet? Yes No

Do you have daily bowel movements? Yes No

Do you have gas, bloating or abdominal pain after eating? Yes No

Please list any prior hormone therapy _____

Recent PSA: _____

History of Prostate problems or Biopsy _____