Confidential Men's Health Hormone Evaluation

Return upon completion to:

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Men's Hypogonadism Health Profile/Questionnaire

Patient Information

Name: _____ Date: _____

Address: _____

Phone: _____

Date of Birth: _____ Height: _____ Weight: _____

Do you have children? Y N Do you hope to have children? Y N

Medical & Social History: Please check the following that apply to you.

_____ High Blood Pressure
_____ High Cholesterol
_____ Cardiovascular Disease
_____ Diabetes Mellitus
_____ Osteoporosis
_____ Benign Prostatic Hyperplasia
_____ Tobacco Use
_____ Asthma/COPD
_____ Alcohol Use
_____ Erectile Dysfunction
_____ Insomnia
_____ Malnutrition
_____ Depression
_____ Cancer: _____
_____ Other: _____

Medical History: List all prescription and non-prescription medications that you are taking. (Include vitamins, herbals and supplements.)

_____

_____

_____

_____

_____

_____

_____

Drug Allergies: _____

_____

Please indicate if you are experiencing the following symptoms:

	Absent	Mild	Moderate	Severe
Fatigue	❑	❑	❑	❑
Decreased muscle mass	❑	❑	❑	❑
Loss in muscle strength	❑	❑	❑	❑
Joint/Muscle Pain	❑	❑	❑	❑
Increase in waist size	❑	❑	❑	❑
Difficulty losing weight	❑	❑	❑	❑
Decreased height	❑	❑	❑	❑
Decreased sex drive	❑	❑	❑	❑
Difficulty establishing and/or maintaining full erections	❑	❑	❑	❑
Decrease in spontaneous early morning erections	❑	❑	❑	❑
Changes in sleep patterns	❑	❑	❑	❑
Decreased mental sharpness	❑	❑	❑	❑
Trouble concentrating	❑	❑	❑	❑
Less enjoyment in personal interests and hobbies	❑	❑	❑	❑

I am _____ years old. I feel _____ years old.

* Please include a copy of all relevant lab work, especially hormone levels, that you have recently obtained.