|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date: |  |
| Contact Phone: | | Email: | |

MALE FORM

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Symptoms | Never | Mild | Moderate | Severe |
| Depressive Mood |  |  |  |  |
| Exhaustion/lack of vitality |  |  |  |  |
| Declining mental ability |  |  |  |  |
| Inability to concentrate / Focus |  |  |  |  |
| Sleep Problems |  |  |  |  |
| Mood changes/irritability |  |  |  |  |
| Weight gain |  |  |  |  |
| Hair falling out |  |  |  |  |
| Joint pain |  |  |  |  |
| Decline in general well being |  |  |  |  |
| Easy to fatigue |  |  |  |  |
| Decreased Muscle Strength |  |  |  |  |
| Decreased morning erection |  |  |  |  |
| Decreased ability to perform sexually |  |  |  |  |
| Low Sexual desire |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family History | | | | |
| Heart Disease |  | No |  | YES |
| Diabetes |  | No |  | YES |
| Osteoporosis |  | No |  | YES |
| Alzheimer’s Dementia |  | No |  | YES |
| Cancer |  | No |  | YES |