AMS Questionnaire

Which of the following symptoms apply to you at this time? Please mark the appropriate box for each symptom. For symptoms that do not apply please mark “none”. Symptoms:

Extremely

None Mild Moderate Severe Severe

| -------- | --------- | -------| --------|

Score = 1 2 3 4 5

1. Decline in your feeling of general well-being

(General state of health, subjective feeling) ....................... □ □ □ □ □

2. Joint pain and muscular ache

(Lower back pain, joint pain, pain in a limb,

general back ache) ……………………………................................. □ □ □ □ □

3. Excessive sweating (unexpected/sudden episodes of

sweating, hot flushes independent of strain)....................... □ □ □ □ □

4. Sleep problems (difficulty in falling asleep, difficulty in

sleeping through, waking up early and feeling tired, poor

sleep, sleeplessness) ............................................................ □ □ □ □ □

5. Increased need for sleep, often feeling tired ................... □ □ □ □ □

6. Irritability (feeling aggressive, easily upset about

little things, moody) ..............................................................□ □ □ □ □

7. Nervousness (inner tension, restlessness, feeling fidgety)□ □ □ □ □

8. Anxiety (feeling panicky) ...................................................□ □ □ □ □

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) .....................□ □ □ □ □

10. Decrease in muscular strength (feeling of weakness).......□ □ □ □ □

11. Depressive mood (feeling down, sad, on the verge

of tears, lack of drive, mood swings, feeling nothing is

of any use) ……………………………………………………………………….....□ □ □ □ □

12. Feeling that you have passed your peak ...........................□ □ □ □ □

13. Feeling burnt out, having hit rock-bottom ........................□ □ □ □ □

14. Decrease in beard growth .................................................□ □ □ □ □

15. Decrease in ability / frequency to perform sexually ......... □ □ □ □ □

16. Decrease in the number of morning erections ..................□ □ □ □ □

17. Decrease in sexual desire / libido (lacking pleasure in sex,

lacking desire for sexual intercourse) ..................................... □ □ □ □ □

Have you any other major symptoms? Yes .......... No ......... If Yes, please describe­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Androgen Aging Males Questionnaire Deficiency in Aging Males Questionnaire.

Instructions: Indicate your response by checking the appropriate box.

1. Do you have a decrease in libido (Sex Drive)? □ Yes □ No

2. Do you have lack of energy? □ Yes □ No

3. Do you have a decrease in strength and/or endurance? □Yes □ No

4. Have you lost height? □ Yes □ No

5. Have you noticed a decreased “enjoyment of life”? □ Yes □ No

6. Are you sad and/or grumpy? □ Yes □ No

7. Are your erections less strong? □ Yes □ No

8. Have you noted a recent deterioration in your ability to play sports? □ Yes □ No

9. Are you falling asleep after dinner? □ Yes □ No

10. Has there been a recent deterioration in your work performance? □ Yes □ No