

Male Hormone Screening Panel

Patient Name: _____

Date: _____

Rate the following as they apply to you. Circle the number which best applies to you, with 1 being Rare and 4 being Severe.

Symptom	Rare	Mild	Frequent	Severe
Fatigue, tiredness or loss of energy	1	2	3	4
Decrease in physical stamina	1	2	3	4
Feelings of depression – a sense that work, marriage or recreational activities have lost significance	1	2	3	4
Decreased libido – less desire for sex	1	2	3	4
Erection or potency problems	1	2	3	4
Loss of early morning erection	1	2	3	4
Dry skin or face or hands	1	2	3	4
Increase in waist size – weight gain, especially around mid-section	1	2	3	4
Increased fat distribution in chest area or hips	1	2	3	4
Feeling burned out, loss of motivation	1	2	3	4
Increase in aches, joints and muscle pains	1	2	3	4
Frequent use of alcohol – now or in the past	1	2	3	4
Increased irritability, anger or bad temper	1	2	3	4
Decrease in muscle mass	1	2	3	4

What prescription and/or non-prescription drugs are you taking (include vitamins, herbal products, or other supplements)? _____

What medical conditions are you being treated for? _____

What medical conditions have you been treated for in the past 5 years? _____