CENTER FOR WOMEN'S HEALTH

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BOARD CERTIFIED GYNECOLOGY

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Name: _____ Date: _____

E-Mail: _____

Male Symptom (please check mark)	Never	Mild	Moderate	severe
Decline in general well being				
Fatigue				
Joint pain /muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritabililty				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
DecliningMental Ability/focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
weight gain/Belly Fat/Inability to lose wt				
Breast Development				
Shrinking Testicles				
Rapid hair loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		