

MALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____

EMAIL: _____

TODAY'S DATE: _____

PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)					
Sleep Problems (difficulty falling asleep or sleeping through the night)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)					
Decline in drive or interest (loss of "zest for life," feeling down or sad)					
Joint and muscular symptoms (poor recovery after workout, inability to add muscle, joint pain, muscle weakness)					
Difficulties with memory (concentration, finding the right word, or retaining information)					
Sexual Desire or Performance (reduced or diminished)					
Erectile changes (weaker erections, loss of morning erections)					
Ejaculations (infrequent or absent)					
Sweating (night sweats or increased episodes of sweating)					
Hair loss, rapid or thinning					
Feeling cold all the time, having cold hands or feet					
Headaches or migraines (increase in frequency or intensity)					
Weight (difficulty losing weight despite diet/exercise)					
Bladder problems (difficulty in urinating, increased need to urinate)					

Other symptoms or unique health circumstances to take into consideration:
