Patient Name _____

Date of Birth ____ / ____ / _____

Appointment with: _____

Today's Date ____ / ____ / _____

Did you know that the symptoms listed below are quite often the result of hormone issues or deficiencies? Please take a minute to fill out this checklist to assist your provider in identifying a potential hormone imbalance.

Hormone Checklist for MEN

Name: _____ **Date of Birth: _____ / _____ /_____**

Symptom *(Please indicate severity with ✓)*	**Never**	**Mild**	**Moderate**	**Severe**
Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental 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 Weight				
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		