Male Hormone Questionnaire

ANDROPAUSE QUIZ

Are You Suffering from Low Testosterone?

Please consider how you feel now and compare that to how you felt in your mid thirties.
0: *Normal or unchanged* ***1:*** *A mild, but noticeable difference* ***2:*** *A moderate or significant* ***3:*** *Severe or marked*

Mental Function
___ Feeling stressed or "burned" out
___ Increased fat in the chest or hip area
___ History of heavy drinking
___ Feeling depressed or negative
___ Feeling irritable or angry
___ Feeling anxious or nervous
___ Feeling mentally fatigued, unable to concentrate
___ Decreased mental sharpness, wit, attention
___ Forgetful, poor memory
___ Decreased assertiveness and/or competitiveness
___ Loss of motivation or initiative to start new projects, participate in hobbies
___ Feeling that work, relationships and hobbies have lost significance

___ ***TOTAL SCORE***

Musculo-skeletal System
___ Fatigue or loss of energy particularly in the afternoon and evening
___ Feeling sore all over, aches in joints and muscles
___ Frequent back or neck pain
___ Decrease in physical stamina or endurance
___ Decrease or less than optimal muscle size, tone and strength
___ Decrease in athletic performance; loss of agility, quickness
___ Decline in flexibility and mobility
___ Difficulty in recovering from physical exercise
___ Increased tendency toward muscle pulls or leg cramps
___ Osteoporosis

___ ***TOTAL SCORE***

Physical Problems
___ Shortness of breath with activities, worsening of asthma or emphysema
___ Lightheadedness, dizzy spells, ringing in the ears or frequent headaches
___ Poor circulation in legs, swelled ankles, varicose veins or hemorrhoids
___ Changes in visual acuity, ability to read fine print
___ Dry skin on face or hands
___ Excessive sweating during the day or night
___ Urinary frequency, reduced flow or force of flow

___ ***TOTAL SCORE***

Metabolic Disease
___ Increase in total cholesterol or triglycerides
___ Decrease in HDL cholesterol
___ Onset of high blood sugar, insulin or diabetes
___ Rise in blood pressure, onset *of* hypertension
___ Development of chest pain, heart disease, blocked arteries
___ Unexplained weight gain, particularly In the midsection
___ Enlarged prostate or increased PSA
___ Loss of body hair, axillary hair, decreased need to shave as frequently

___ ***TOTAL SCORE***

Sexual Function
___ Decrease in spontaneous early morning erections
___ Decreased libido or desire for sex*
___ Decrease in fullness of erection*
___ Decreased volume or strength of force of climax
___ Difficulty in maintaining full erection
___ Difficulty in achieving an erection

___ ***TOTAL SCORE***

TOTAL TESTOSTERONE SCORE _____
(0-5-unlikely; 6-10 possible; 10+ probable)

You are at moderate risk for low testosterone levels if you answer yes to anyone of the questions below.

___ I have a history of adult mumps, orchitis or other testicular problems
___ I have had a prostate operation or persistent inflammation / infection of the prostate
___ I have had a vasectomy
___ Repeated use of prednisone, inhaled steroids
___ Use of Proscar, Propecia
___ Prior use of anabolic steroids, “pro-hormones”
___ Use of "statins", chronic anti-fungals, anti-convulsants, Amiodarone, thiazide diuretics propylthiouracil, cancer chemotherapy
___ Smoke more than 1pack of cigarettes per day
___ Drink alcohol regularly, occasionally to excess
___ More than 20 pounds overweight
___ Have used Marijuana or other recreational drugs regularly In the past

Testosterone Score Overview
The decline in testosterone may be subtle but is rarely accompanied by only one symptom severely. Rather it affects all the tissues that contain testosterone receptors, which is the whole body. A sudden loss of erectile capacity by itself is not likely to be due to a sudden testosterone deficiency. Likewise, the development of one symptom or another alone is not a red flag for the"Male Menopause". Usually, decline in testosterone is gradual with a slow steady accompaniment of systemic symptoms that creep in like a "thief in the night.” Changes in energy, desire for usual activities, interest in sex, soreness and stiffness together are strong signals of change in testosterone, but require testing to confirm the status of the androgen hormones. **(* if both are positive deficiency likely)**

Hormone Balance Questionnaire For Men

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age:_____ Height: _____ Weight: _____

Primary Care Doctor: _____

HEALTH HISTORY

Do you have a personal or family history of any of the following?

Prostate Cancer __ No __ Yes (relationship) _____

Breast Cancer __ No __ Yes (relationship) _____

Osteoporosis __ No __ Yes (relationship) _____

Have you had any of the following tests?

PSA	__ No	__ Yes (Date) _____	Abnormal?	__ No	__ Yes
DEXA Scan (Bone Density - Screen for Osteoporosis)	__ No	__ Yes (Date) _____	Abnormal?	__ No	__ Yes
Colonoscopy	__ No	__ Yes (Date) _____	Abnormal?	__ No	__ Yes

MEDICAL CONDITIONS / DISEASES *(please check all that apply)*

___ Heart Disease (heart attack, CHF, etc.)
___ High Cholesterol
___ High Blood Pressure
___ Cancer (type_____)
___ Ulcers (stomach, esophagus)
___ Thyroid Problems
___ Hormone Related Issues
___ Lung Problems (asthma, COPD, etc.)
___ Blood Clotting Problems o Diabetes
___ Arthritis or Joint Problems o Depression
___ Epilepsy or Seizure Disorder
___ Headaches / Migraines
___ Eye Disease (glaucoma, etc.)
___ Liver or Gastrointestinal Disorder

Other (please explain)

_____

_____

_____

_____

PREVIOUS SURGERIES / HOSPITALIZATIONS *(please list)*

Have you had prostate surgery? __ No __ Yes (date of surgery) _____

Please list any other surgeries you have had:

_____

_____

_____

_____

LIFESTYLE

Do you smoke? __ No __ Yes (details) _____

Do you drink alcohol? __ No __ Yes (details) _____

Do you use recreational drugs? __ No __ Yes (details) _____

Do you exercise? __ No __ Yes (details) _____

ALLERGIES / MEDICATION INTOLERANCES (please list)

_____

_____

___ I have no allergies or medication intolerances that I know of.

MEDICATIONS

Current Prescriptions and Over-the-Counter Medications

_____ _____

_____ _____

_____ _____

_____ _____

List Hormones Currently or Previously Taken

_____ _____

_____ _____

_____ _____

NUTRITIONAL SUPPLEMENTS *(please circle the product you are using):*

___ Vitamins (multiple or single vitamins such as B complex, E, C, D, beta carotene, other)

___ Minerals (calcium, magnesium, chromium, iron, zinc, copper, other)

___ Herbs (ginseng, gingko biloba, Echinacea, medicinal teas, other)

___ Enzymes (Digestive, papaya, bromelain, CoQlO, other)

___ Nutritional / Protein Supplements (shark cartilage, protein powders, amino acids, fish / flaxseed oil, other)

Other *(please list)*

_____

_____

___ I do not take any nutritional supplements

CURRENT SYMPTOMS

For each item identified below, circle the number that best fits the symptoms you are experiencing.

0 = none • 1 = mild • 2 = moderate • 3 = severe

Decreased Muscle Mass	0	1	2	3	Reduced Energy	0	1	2	3
Weight Gain	0	1	2	3	Loss of Sex Drive	0	1	2	3
Difficulty Falling Asleep	0	1	2	3	Erectile Dysfunction	0	1	2	3
Difficulty Staying Asleep	0	1	2	3	Urinary Problems	0	1	2	3
Morning Fatigue	0	1	2	3	Urinary Tract Infections	0	1	2	3
Evening Fatigue	0	1	2	3	Urinary Incontinence	0	1	2	3
Depression	0	1	2	3	Thinning Skin	0	1	2	3
Anxiety	0	1	2	3	Oily Skin	0	1	2	3
Irritable	0	1	2	3	Weight Gain - Hips	0	1	2	3
Memory Lapses	0	1	2	3	Weight Gain - Waist	0	1	2	3
Tearfulness	0	1	2	3	Decreased Muscle Mass	0	1	2	3
Foggy Thinking	0	1	2	3	Sugar / Carb Cravings	0	1	2	3
Stress	0	1	2	3	Unusual Sweating	0	1	2	3
Hair Loss on Scalp	0	1	2	3	Hoarseness	0	1	2	3
Increased Facial of Body Hair	0	1	2	3	Bulging Eyes	0	1	2	3
Dry / Brittle Hair	0	1	2	3	Slowed Reflexes	0	1	2	3
Dry / Brittle Nails	0	1	2	3	Cold Body Temperature	0	1	2	3
Acne	0	1	2	3	Blood Pressure Problems	0	1	2	3

DO YOU FEEL LIKE A SHADOW OF YOUR FORMER SELF?

Take the Low T (testosterone) quiz*.

		Yes	No
1.	Do you have a decrease in libido (sex drive)?	☐	☐
2.	Do you have a lack of energy?	☐	☐
3.	Do you have a decrease in strength and/or endurance?	☐	☐
4.	Have you lost height?	☐	☐
5.	Have you noticed a decreased "enjoyment of life"?	☐	☐
6.	Are you sad and/or grumpy?	☐	☐
7.	Are your erections less strong?	☐	☐
8.	Have you noticed a recent deterioration in your ability to play sports?	☐	☐
9.	Are you falling asleep after dinner?	☐	☐
10.	Has there been a recent deterioration in your work performance?	☐	☐