

Male Symptom Assessment

Name: _____

Date: _____

Symptom (please place check mark)	Never	Mild	Moderate	Severe
Fatigue.....				
Night sweats.....				
Hot flashes.....				
Decreased focus/mental clarity/concentration.....				
Decreased sex drive.....				
Decreased ability to perform sexually.....				
Anxiety.....				
Depressed mood.....				
Joint pain/achiness.....				
Moodiness/Irritability				
Decreased motivation				
Chronic constipation				
Feeling cold all the time.....				
Restless sleep/wake frequently/insomnia.....				
Breast Development.....				
Decrease in body hair.....				
Rapid Hair Loss.....				
Decreased muscle mass				
New headaches/migraines.....				
Weight Gain/Belly Fat/Inability to Lose Weight				
Decline in general well-being.....				
Decreased morning erections				
Inability to maintain erection.....				
Tried Viagra/Cialis without benefit.....				

Other symptoms that concern you:
