PREMIER CARE
MEDICAL SERVICES

Male Checklist

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*
For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. Decline in your feeling of general well-being (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2. Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3. Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4. Sleep problems (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5. Increased need for sleep, often feeling tired	☐	☐	☐	☐	☐
6. Irritability (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7. Nervousness (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. Anxiety (feeling panicky)	☐	☐	☐	☐	☐
9. Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10. Decrease in muscular strength (feeling of weakness)	☐	☐	☐	☐	☐
11. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12. Feeling that you have passed your peak	☐	☐	☐	☐	☐
13. Feeling burnt out, having hit rock-bottom	☐	☐	☐	☐	☐
14. Decrease in beard growth	☐	☐	☐	☐	☐
15. Decrease in ability/frequency to perform sexually	☐	☐	☐	☐	☐
16. Decrease in the number of morning erections	☐	☐	☐	☐	☐
17. Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address._____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?_____

_____**Recent PSA:**_____**Recent Digital Rectal Exam (Date):**_____**Normal / Abnormal**

History of Prostate problems or Biopsy. If so, please provide details._____

FOR OFFICE USE ONLY

CHART ID:_____ DOB:_____ APPT DATE:_____

Rev 062019