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.

		SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
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 Jan 2022

MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

☐For symptoms that do not apply, please mark NONE.

		SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1.	**Hot flashes, sweating** (episodes of sweating)		☐	☐	☐	☐	☐
2.	**Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)		☐	☐	☐	☐	☐
3.	**Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)		☐	☐	☐	☐	☐
4.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)		☐	☐	☐	☐	☐
5.	**Irritability** (feeling nervous, inner tension, feeling aggressive)		☐	☐	☐	☐	☐
6.	**Anxiety** (inner restlessness, feeling panicky)		☐	☐	☐	☐	☐
7.	**Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)		☐	☐	☐	☐	☐
8.	**Sexual problems** (change in sexual desire, in sexual activity and satisfaction)		☐	☐	☐	☐	☐
9.	**Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)		☐	☐	☐	☐	☐
10.	**Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)		☐	☐	☐	☐	☐
11.	**Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)		☐	☐	☐	☐	☐

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?

_____

_____

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CHART ID:_____ **DOB:**_____ **APPT DATE:**_____

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