Health Assessment for Men

Name: ____________________ Date: ____________________

Cell# ____________________ Weight: ____________________

Email: ____________________

Symtoms (please check mark)	Never	Mild	Moderate	Severe
Fatique				
Sleep problems				
Increased sweating				
Irritability				
Increased need for sleep				
Nervousness				
Anxiety				
Depressed Mood				
Exhaustion/ lack vitality				
Declining need for sleep				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/ Belly Fat/ Inability to Lose				
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				

Current/ Previous Testoterone Therapy Treatment

		Dosage
Injections	____________________	____________________
Creams/Gels	____________________	____________________
Pellets	____________________	____________________