Name: _____Age:____ Initial (1st) Date: _____ *Follow-up (2nd) Date*: _____

MEN SYMPTOM REVIEW (Women Turn Page Over). ONLY 1 FORM NEEDED

Check NONE if no symptoms. Check Mild to Moderate or Severe symptoms, if currently experiencing. 1st or 2nd visit.

Initial visit	*Follow-up*		**Initial visit 1st visit**	**Initial visit**	*Follow-up 2nd visit*	*Follow -up*	
None	***None***	**Symptoms**	**Mild to Mod**	**Severe**	***Mild to Mod***	***Severe***	
		Decreased Urine Flow					**Estrogen Dominance**
		Increased Urinary Urge					
		Prostate Problems					
		Weight Gain – Chest / Hips					**Low Progesterone**
		Weight Gain – Waist					
		Decreased Libido/Sex Drive					**Metabolic Syndrome (high sugar)**
		Decreased Erections					
		Ringing in Ears					
		High Cholesterol					
		Elevated Triglycerides (fats)					
		Hot Flashes					
		Night Sweats					
		Decreased Mental Sharpness					
		Increased Forgetfulness					
		Decreased Muscle Size					**Low Androgens**
		Decreased Flexibility					
		Sore Muscles					
		Increased Joint Pain					
		Bone Loss or Osteoporosis					
		Rapid Aging					
		Thinning Skin					
		Decreased Stamina					
		Burned Out Feeling					**Adrenal Cortisol Imbalance (stress gland)**
		Stress					
		Morning Fatigue					
		Evening Fatigue					
		Difficulty Sleeping					
		No Drive or Apathy					
		Depressed					
		Mental Fatigue					
		Anxious					
		Irritable					
		Nervous					
		Headaches					
		Sugar Cravings					
		Dizzy Spells					
		Cold Body Temperature					
		Enlarged Thyroid or Goiter					**Thyroid & Iodine Poor Balance**
		Hoarseness					
		Hair Dry or Brittle					
		Constipation					
		Slow Pulse Rate					**Other Hormonal Imbalance**
		Rapid Heartbeat					
		Heart Palpitations					
		Infertility problems					
		Allergies					

Additional Symptoms: _____