ALPHA INTERNAL MEDICINE

BioTE questionnaire Please take the time to complete this and return it upon check-in so that we may better meet your needs.

Please circle the best frequency description of the following symptoms:

Symptom				
Fatigue	Never	Mild	Moderate	Severe
Mood changes	Never	Mild	Moderate	Severe
Decreased mental ability	Never	Mild	Moderate	Severe
Excessive sweating Night sweats/Hot flashes	Never	Mild	Moderate	Severe
Weight gain	Never	Mild	Moderate	Severe
Decreased sex drive	Never	Mild	Moderate	Severe
Sleep problems	Never	Mild	Moderate	Severe
Always cold	Never	Mild	Moderate	Severe
Decreased muscle strength	Never	Mild	Moderate	Severe
Hair loss/breakage	Never	Mild	Moderate	Severe
Joint pain/Muscle aches	Never	Mild	Moderate	Severe

Please circle any personal or family history that applies:

Breast cancer DVT/Pulmonary embolism Prostate cancer

PLEASE PRINT CLEARLY!

Name:____ **Gender:**__________

Phone:_________________________ **Date of birth:**_________________________

Email:____