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Medford, OR 97504

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Name: _____
DOB: _____

Male Hormonal Symptom Evaluation Sheet

	Absent	Mild	Moderate	Severe
Hot Flashes				
Night Sweats				
Memory Loss				
Mental Fog				
Mood Swings				
Difficulty Sleeping/Insomnia				
Anxiety				
Bloating				
Headaches				
Weight Gain				
Food Cravings				
Depression				
Low Libido				
Low Sex Sensation				
Irritability				
Fatigue				
Hair Loss				
Dry Skin/Hair				
Acne/Oily skin				
Other Symptoms				

What is your stress level? Range 1-10, 10 being the highest _____
What exercises do you do? _____
How many starches do you eat per day? _____
i.e. bread, crackers, rice, potatoes, cereal, etc.
How many servings of protein do you have per day? _____
i.e. poultry, meat, tofu, eggs, etc.
How many hours do you sleep at night/day? _____
Frequency of period, number of days apart? _____