Male HRT Symptom Questionnaire

Patient Name_____ DOB_____ Date_____

In the past 2 weeks, please indicate if you have had any of these symptoms, and rate the symptom from 1 to 5. 1 - not too much of a problem - 5 - very much a problem.

Acne or Oily Skin	1	2	3	4	5	N/A	
Decreased Morning Erections	1	2	3	4	5	N/A	
Decreased Quality of Erections	1	2	3	4	5	N/A	
Erectile Dysfunction	1	2	3	4	5	N/A	
Low Libido	1	2	3	4	5	N/A	
Lack of Motivation	1	2	3	4	5	N/A	
Sleep disturbance/insomnia	1	2	3	4	5	N/A	
Fatigue	1	2	3	4	5	N/A	
Muscle gain/loss	1	2	3	4	5	N/A	
Depression Symptoms	1	2	3	4	5	N/A	
Swelling in hands/feet	1	2	3	4	5	N/A	
Brain fog or Memory loss	1	2	3	4	5	N/A	
Decreased concentration	1	2	3	4	5	N/A	
Night sweats/hot flashes	1	2	3	4	5	N/A	
Anxiety/irritability	1	2	3	4	5	N/A	
Mood Swings	1	2	3	4	5	N/A	
Tearful	1	2	3	4	5	N/A	
Craving Sweets or Salt	1	2	3	4	5	N/A	
Constipation or Diarrhea	1	2	3	4	5	N/A	
Poor recovery after workouts	1	2	3	4	5	N/A	
Difficulty losing weight	1	2	3	4	5	N/A	
Hair Loss	1	2	3	4	5	N/A	