

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	

Complaints and Concerns

What do you hope to achieve in your visit with us? _____

Date of symptom or injury onset? _____

If you had a magic wand and you could erase three problems, what would they be?

1. _____
2. _____
3. _____

Current Height: _____ Current weight: _____

Medical Symptoms Questionnaire (MSQ)

Rate each of the following symptoms based upon your typical health profile for the past 30 days:

Point Scale	0	-	Never or almost never have the symptom
	1	-	Occasionally have it, effect is not severe
	2	-	Occasionally have it, effect is severe
	3	-	Frequently have it, effect is not severe
	4	-	Frequently have it, effect is severe

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	Total _____

EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision (does not include near or far-sightedness)	Total _____

EARS	_____	Itchy ears	
	_____	Earaches, Ear infections	
	_____	Drainage from ear	
	_____	Ringings in ears, hearing loss	Total _____

NOSE	_____	Stuffy noses	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	Total _____

MOUTH/THROAT

_____	Chronic coughing	
_____	Gagging, frequent need to clear throat	
_____	Sore throat, hoarseness, loss of voice	
_____	Swollen or discolored tongue, gums. Lips	
_____	Canker sores	Total _____

SKIN _____	Acne	
_____	Hives, rashes, dry skin	
_____	Hair loss	
_____	Flushing, hot flashes	
_____	Excessive sweating	Total _____

HEART _____	Irregular or skipped heartbeat	
_____	Rapid or pounding heartbeat	
_____	Chest pain	Total _____

LUNGS _____	Chest congestion	
_____	Asthma, bronchitis	
_____	Shortness of breath	
_____	Difficulty breathing	Total _____

DIGESTIVE TRACT _____	Nausea, vomiting	
_____	Diarrhea	
_____	Constipation	
_____	Bloated feeling	
_____	Belching, passing gas	
_____	Heartburn	
_____	Intestinal/stomach pain	Total _____

JOINTS/MUSCLE _____	Pain or aches in joints	
_____	Arthritis	
_____	Stiffness or limitation of movement	
_____	Pain or aches in muscles	
_____	Feeling of weakness or tiredness	Total _____

Weight _____	Binge eating/drinking	
_____	Craving certain foods	
_____	Excessive weight	
_____	Compulsive eating	
_____	Water retention	
_____	Underweight	Total _____

Energy/Activity

_____	Fatigue, sluggishness	
_____	Apathy, lethargy	
_____	Hyperactivity	
_____	Restlessness	
		Total _____

Mind

_____	Poor memory	
_____	Confusion, poor comprehension	
_____	Poor concentration	
_____	Poor physical coordination	
_____	Difficulty in making decisions	
_____	Stuttering or stammering	
_____	Slurred speech	
_____	Learning disabilities	
		Total _____

Emotions

_____	Mood swings	
_____	Anxiety, fear, nervousness	
_____	Anger, irritability, aggressiveness	
_____	Depression	
		Total _____

Other

_____	Frequent illness	
_____	Frequent or urgent urination	
_____	Genital itch or discharge	
		Total _____

Grand Total: _____

Additional Comments:
