

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Initial (1<sup>st</sup>) Date: \_\_\_\_\_ Follow-up (2<sup>nd</sup>) 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. 1<sup>st</sup> or 2<sup>nd</sup> visit.

Initial visit	Follow-up		Initial visit 1 <sup>st</sup> visit	Initial visit	Follow-up 2 <sup>nd</sup> visit	Follow-up	
None	None	Symptoms	Mild to Mod	Severe	Mild to Mod	Severe	
		Decreased Urine Flow					<b>Estrogen Dominance</b>
		Increased Urinary Urge					
		Prostate Problems					
		Weight Gain – Chest / Hips					
		Weight Gain – Waist					
		Decreased Libido/Sex Drive					<b>Low Progesterone</b>
		Decreased Erections					
		Ringing in Ears					
		High Cholesterol					
		Elevated Triglycerides (fats)					
		Hot Flashes					
		Night Sweats					
		Decreased Mental Sharpness					
		Increased Forgetfulness					
		Decreased Muscle Size					
		Decreased Flexibility					
		Sore Muscles					
		Increased Joint Pain					
		Bone Loss or Osteoporosis					
		Rapid Aging					
		Thinning Skin					
		Decreased Stamina					
		Burned Out Feeling					<b>Metabolic Syndrome (high sugar)</b>
		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					<b>Adrenal Cortisol Imbalance (stress gland)</b>
		Hoarseness					
		Hair Dry or Brittle					
		Constipation					
		Slow Pulse Rate					
		Rapid Heartbeat					
		Heart Palpitations					
		Infertility problems					
		Allergies					

Additional Symptoms: \_\_\_\_\_