



Name: _____ Date of birth: _____

MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Sweating (night sweats or excessive sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased need for sleep or falls asleep easily after a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive mood (feeling down, sad, lack of drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems (change in sexual desire or in sexual performance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased need to urinate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erectile changes (weaker erections, loss of morning erections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with thinking, concentrating or reasoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty learning new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble thinking of the right word to describe persons, places or things when speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in frequency or intensity of headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid hair loss or thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold all the time or have cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infrequent or absent ejaculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total score	_____				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80