Men's Health Profile/Questionnaire

Patient Information

Name: _____ Date: _____

Address: _____

Phone: _____

Date of Birth: _____ Height: _____ Weight: _____

BMI (Pharmacist will calculate): _____ (BMI= Wt. in Kg/Ht. in meters^2)

BMI Results for Adults Over 35:

19-26.9	Recommended	30-39.9	Obese
27-29.9	Overweight	40 (+)	Morbidly Obese

Medical & Social History: Please check the following that apply to you.

___High Blood Pressure
___High Cholesterol
___Cardiovascular Disease
___Diabetes Mellitus
___Osteoporosis
___Benign Prostatic Hyperplasia
___Tobacco Use
___Asthma/COPD
___Alcohol Use
___Erectile Dysfunction
___Insomnia
___Malnutrition
___Depression
___Cancer: _____
___Other: _____

Medication History: List all prescription and non-prescription medications that you are taking. (Include vitamins, herbals and supplements.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Drug Allergies: _____

_____

_____

Circle Yes or No to the following questions. If yes, indicate if Mild, Moderate or Severe.

1. Do you feel more fatigued and/or tired than usual? **Yes** **No**
   If yes, circle: **Mild** **Moderate** **Severe**

2. Have you noticed a decrease in your muscle mass? **Yes** **No**
   If yes, circle: **Mild** **Moderate** **Severe**

3. Have you experienced a loss in muscle strength? **Yes** **No**
   If yes, circle: **Mild** **Moderate** **Severe**

4. Have you experienced an increase in joint and/or muscle pains? **Yes** **No**
   If yes, circle: **Mild** **Moderate** **Severe**

5. Have you noticed an increase in your waist size? **Yes** **No**
   If yes, circle: **Mild** **Moderate** **Severe**

6. Do you have trouble losing weight? **Yes** **No**
   If yes, circle: **Mild** **Moderate** **Severe**

7. Have you experienced a loss in height? **Yes** **No**
   If yes, circle: **Mild** **Moderate** **Severe**

8. Do you have a decrease in your sex drive? **Yes** **No**
   If yes, circle: **Mild** **Moderate** **Severe**

9. Have you experienced difficulty in establishing and/or maintaining full erections? **Yes** **No**
   If yes, circle: **Mild** **Moderate** **Severe**

10. Do you have a decrease in spontaneous early morning erections? **Yes** **No**
    If yes, circle: **Mild** **Moderate** **Severe**

11. Have you experienced changes in your usual sleep pattern? **Yes** **No**
    If yes, circle: **Mild** **Moderate** **Severe**

12. Do you feel a decrease in your mental sharpness? **Yes** **No**
    If yes, circle: **Mild** **Moderate** **Severe**

13. Have you had trouble concentrating? **Yes** **No**
    If yes, circle: **Mild** **Moderate** **Severe**

14. Do you experience less enjoyment in personal interests and hobbies? **Yes** **No**
    If yes, circle: **Mild** **Moderate** **Severe**

15. I am _____ years old. I feel _____ years old.