

ANDROPAUSE QUIZ

Are You Suffering from Low Testosterone?

Please consider how you feel now and compare that to how you felt in your mid thirties.

0: Normal or unchanged **1:** A mild, but noticeable difference **2:** A moderate or significant **3:** Severe or marked

Mental Function

- Feeling stressed or "burned" out
- Increased fat in the chest or hip area
- History of heavy drinking
- Feeling depressed or negative
- Feeling irritable or angry
- Feeling anxious or nervous
- Feeling mentally fatigued, unable to concentrate
- Decreased mental sharpness, wit, attention
- Forgetful, poor memory
- Decreased assertiveness and/or competitiveness
- Loss of motivation or initiative to start new projects, participate in hobbies
- Feeling that work, relationships and hobbies have lost significance

___ **TOTAL SCORE**

Musculo-skeletal System

- Fatigue or loss of energy particularly in the afternoon and evening
- Feeling sore all over, aches in joints and muscles
- Frequent back or neck pain
- Decrease in physical stamina or endurance
- Decrease or less than optimal muscle size, tone and strength
- Decrease in athletic performance; loss of agility, quickness
- Decline in flexibility and mobility
- Difficulty in recovering from physical exercise
- Increased tendency toward muscle pulls or leg cramps
- Osteoporosis

___ **TOTAL SCORE**

Physical Problems

- Shortness of breath with activities, worsening of asthma or emphysema
- Lightheadedness, dizzy spells, ringing in the ears or frequent headaches
- Poor circulation in legs, swelled ankles, varicose veins or hemorrhoids
- Changes in visual acuity, ability to read fine print
- Dry skin on face or hands
- Excessive sweating during the day or night
- Urinary frequency, reduced flow or force of flow

___ **TOTAL SCORE**

Metabolic Disease

- Increase in total cholesterol or triglycerides
- Decrease in HDL cholesterol
- Onset of high blood sugar, insulin or diabetes
- Rise in blood pressure, onset of hypertension
- Development of chest pain, heart disease, blocked arteries

- Unexplained weight gain, particularly in the midsection
- Enlarged prostate or increased PSA
- Loss of body hair, axillary hair, decreased need to shave as frequently

___ **TOTAL SCORE**

Sexual Function

- Decrease in spontaneous early morning erections
- Decreased libido or desire for sex*
- Decrease in fullness of erection*
- Decreased volume or strength of force of climax
- Difficulty in maintaining full erection
- Difficulty in achieving an erection

___ **TOTAL SCORE**

TOTAL TESTOSTERONE SCORE _____
(0-5-unlikely; 6-10 possible; 10+ probable)

You are at moderate risk for low testosterone levels if you answer yes to anyone of the questions below.

- I have a history of adult mumps, orchitis or other testicular problems
- I have had a prostate operation or persistent inflammation / infection of the prostate
- I have had a vasectomy
- Repeated use of prednisone, inhaled steroids
- Use of Proscar, Propecia
- Prior use of anabolic steroids, "pro-hormones"
- Use of "statins", chronic anti-fungals, anti-convulsants, Amiodarone, thiazide diuretics propylthiouracil, cancer chemotherapy
- Smoke more than 1 pack of cigarettes per day
- Drink alcohol regularly, occasionally to excess
- More than 20 pounds overweight
- Have used Marijuana or other recreational drugs regularly in the past

Testosterone Score Overview

The decline in testosterone may be subtle but is rarely accompanied by only one symptom severely. Rather it affects all the tissues that contain testosterone receptors, which is the whole body. A sudden loss of erectile capacity by itself is not likely to be due to a sudden testosterone deficiency. Likewise, the development of one symptom or another alone is not a red flag for the "Male Menopause". Usually, decline in testosterone is gradual with a slow steady accompaniment of systemic symptoms that creep in like a "thief in the night." Changes in energy, desire for usual activities, interest in sex, soreness and stiffness together are strong signals of change in testosterone, but require testing to confirm the status of the androgen hormones. (*** if both are positive deficiency likely**)

HORMONE BALANCE QUESTIONNAIRE FOR MEN

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Primary Care Doctor: _____

HEALTH HISTORY

Do you have a personal or family history of any of the following?

Prostate Cancer No Yes (relationship) _____

Breast Cancer No Yes (relationship) _____

Osteoporosis No Yes (relationship) _____

Have you had any of the following tests?

PSA No Yes (Date) _____ Abnormal? No Yes

DEXA SCAN (Bone Density - Screen for Osteoporosis) No Yes (Date) _____ Abnormal? No Yes

Colonoscopy No Yes (Date) _____ Abnormal? No Yes

MEDICAL CONDITIONS / DISEASES *(please check all that apply)*

Heart Disease (heart attack, CHF, etc.)

High Cholesterol

High Blood Pressure

Cancer (type _____)

Ulcers (stomach, esophagus)

Thyroid Problems

Hormone Related Issues

Lung Problems (asthma, COPD, etc.)

Blood Clotting Problems or Diabetes

Arthritis or Joint Problems or Depression

Epilepsy or Seizure Disorder

Headaches / Migraines

Eye Disease (glaucoma, etc.)

Liver or Gastrointestinal Disorder

Other (please explain)

PREVIOUS SURGERIES / HOSPITALIZATIONS (please list)

Have you had prostate surgery? No Yes (date of surgery) _____

Please list any other surgeries you have had:

LIFESTYLE

Do you smoke? No Yes (details) _____

Do you drink alcohol? No Yes (details) _____

Do you use recreational drugs? No Yes (details) _____

Do you exercise? No Yes (details) _____

ALLERGIES / MEDICATION INTOLERANCES (please list)

I have no allergies or medication intolerances that I know of.

MEDICATIONS

Current Prescriptions and Over-the-Counter Medications

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

List Hormones Currently or Previously Taken

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<hr/>	<hr/>
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NUTRITIONAL SUPPLEMENTS (please circle the product you are using):

___ Vitamins (multiple or single vitamins such as B complex, E, C, D, beta carotene, other)

___ Minerals (calcium, magnesium, chromium, iron, zinc, copper, other)

___ Herbs (ginseng, ginkgo biloba, Echinacea, medicinal teas, other)

___ Enzymes (Digestive, papaya, bromelain, CoQ10, other)

___ Nutritional / Protein Supplements (shark cartilage, protein powders, amino acids, fish / flaxseed oil, other)

Other (please list)

___ I do not take any nutritional supplements

CURRENT SYMPTOMS

For each item identified below, circle the number that best fits the symptoms you are experiencing.

0 = none • 1 = mild • 2 = moderate • 3 = severe

Decreased Muscle Mass	0	1	2	3	Reduced Energy	0	1	2	3
Weight Gain	0	1	2	3	Loss of Sex Drive	0	1	2	3
Difficulty Falling Asleep	0	1	2	3	Erectile Dysfunction	0	1	2	3
Difficulty Staying Asleep	0	1	2	3	Urinary Problems	0	1	2	3
Morning Fatigue	0	1	2	3	Urinary Tract Infections	0	1	2	3
Evening Fatigue	0	1	2	3	Urinary Incontinence	0	1	2	3
Depression	0	1	2	3	Thinning Skin	0	1	2	3
Anxiety	0	1	2	3	Oily Skin	0	1	2	3
Irritable	0	1	2	3	Weight Gain - Hips	0	1	2	3
Memory Lapses	0	1	2	3	Weight Gain - Waist	0	1	2	3
Tearfulness	0	1	2	3	Decreased Muscle Mass	0	1	2	3
Foggy Thinking	0	1	2	3	Sugar / Carb Cravings	0	1	2	3
Stress	0	1	2	3	Unusual Sweating	0	1	2	3
Hair Loss on Scalp	0	1	2	3	Hoarseness	0	1	2	3
Increased Facial or Body Hair	0	1	2	3	Bulging Eyes	0	1	2	3
Dry / Brittle Hair	0	1	2	3	Slowed Reflexes	0	1	2	3
Dry / Brittle Nails	0	1	2	3	Cold Body Temperature	0	1	2	3
Acne	0	1	2	3	Blood Pressure Problems	0	1	2	3

DO YOU FEEL LIKE A SHADOW OF YOUR FORMER SELF?

Take the Low T (testosterone) quiz*.

	Yes	No
1. Do you have a decrease in libido (sex drive)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a lack of energy?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a decrease in strength and/or endurance?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you lost height?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you noticed a decreased "enjoyment of life"?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you sad and/or grumpy?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are your erections less strong?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you noticed a recent deterioration in your ability to play sports?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you falling asleep after dinner?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has there been a recent deterioration in your work performance?	<input type="checkbox"/>	<input type="checkbox"/>