



MALE **SYMPTOM CHECKLIST**

Name: _____ **Date:** _____

Which of the following symptoms apply to you at this time? Please mark the appropriate one for each symptom.

- | | | |
|---|---|---|
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Foggy thinking | <input type="checkbox"/> Cold body temperature |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Difficulty losing weight |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Decreased sexual desire | <input type="checkbox"/> Reduced muscle mass |
| <input type="checkbox"/> Reduced energy | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Reduced bone mass |
| <input type="checkbox"/> Burned out feeling | <input type="checkbox"/> Decreased a.m. erections | <input type="checkbox"/> Blood sugar issues |
| <input type="checkbox"/> Decreased stamina | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Infertility issues |
| <input type="checkbox"/> Muscle or joint pain | <input type="checkbox"/> Decreased beard growth | |

Do you have any other major symptoms? If yes, please describe:
