Name: _____

Date of Birth: _____

Today's Date: _____

LOW TESTOSTERONE

1. Have you ever had mumps in your life? **YES / NO**

2. How many times a night do you wake up to urinate?

_____

3. Have you ever had an enlarged prostate? **YES / NO**

4. What medications are you **currently** using for this problem?

_____

What medications have you tried for this problem in the **past**?

_____

5. Have you ever been told you snore? **YES / NO**

6. Any family history of pituitary tumors or high calcium? **YES / NO**

7. Any family history of prostate cancer? **YES / NO**

Circle if you are experiencing any of these symptoms:

- **(circle here if NONE of the BELOW)**

- decreased libido
- problems with erections
- nipple tenderness
- nipple discharge
- breast growth

- fatigue
- body aches
- headache
- change in vision
- dizziness

- nausea
- vomiting
- diarrhea

- change in shoe size / ring size / hat size
- separation of your teeth
- changes in your jaw size
- increased pigmentation at the gums or creases of hands
- new stretch marks

- acne
- baldness
- worsened sleep apnea
- pain/redness/swelling at one leg

- feeling more cold than others
- feeling more hot than others
- tremor
- palpitations

- weakened urine stream
- having to wait for urine stream to start
- having to wake up from sleep more to urinate