



## MALE REASSESSMENT PATIENT QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_

### CURRENT SYMPTOMS:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Muscle weakness  | <input type="checkbox"/> Difficulty Sleeping  | <input type="checkbox"/> Decreased libido                      |
| <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Bowel symptoms<br>(bloating/diarrhea) |
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Weight Gain          | <input type="checkbox"/> Stress                                |
| <input type="checkbox"/> Foggy thinking   | <input type="checkbox"/> Muscle/joint aches   |  |
| <input type="checkbox"/> Mental sharpness | <input type="checkbox"/> Erectile function    |  |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Depression/anxiety   |  |
| <input type="checkbox"/> Mood             |   |  |

Other \_\_\_\_\_

### WHAT ARE YOUR HEALTH GOALS FOR THE YEAR?

<b>CURRENT MEDICATIONS:</b>	<b>CURRENT SUPPLEMENTS:</b>
_____	_____
_____	_____
_____	_____
_____	_____

### CHANGES IN PERSONAL MEDICAL HISTORY IN THE PAST YEAR:

(ie: illnesses, hospitalization, abnormal investigations)

\_\_\_\_\_  
\_\_\_\_\_

### CHANGES IN FAMILY MEDICAL HISTORY IN THE PAST YEAR:

(ie: cancer, heart disease, diabetes, prostate cancer)

\_\_\_\_\_  
\_\_\_\_\_

CURRENT ALCOHOL INTAKE: \_\_\_\_\_

CURRENT CAFFEINE INTAKE: \_\_\_\_\_

SMOKER/NON-SMOKER (please circle one)

PACKS PER DAY: \_\_\_\_\_

CURRENT STRESSORS:

\_\_\_\_\_

DATE OF LAST PSA

DATE OF LAST CHOLESTEROL

DATE OF LAST BLOOD SUGAR

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PLEASE ALSO COMPLETE YOUR 3 DAY DIET AND EXERCISE LOG FOR THIS APPOINTMENT. THANK YOU.