



MALE REASSESSMENT PATIENT QUESTIONNAIRE

NAME: _____

DATE: _____

PHYSICIAN: _____

CURRENT SYMPTOMS:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Libido | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Stress | |
| <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Muscle/joint aches | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Weight gain | |
| <input type="checkbox"/> Bowel symptoms (bloating/diarrhea) | <input type="checkbox"/> Foggy thinking | |

WHAT ARE YOUR HEALTH GOALS FOR THE YEAR?

CURRENT MEDICATIONS:

CURRENT SUPPLEMENTS:

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, osteoporosis)

CURRENT ALCOHOL INTAKE: _____

CURRENT CAFFEINE INTAKE: _____

SMOKER/NON-SMOKER (please circle one)

PACKS PER DAY: _____

CURRENT STRESSORS:

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