Female Symptom Checklist

Name:___________________________________E-Mail________________________________Date:________

Symptoms (please check mark)	Never	Mild	Moderate	Severe
Fatigue				
Memory Loss				
Mental Confusion				
Decreased Sex Drive or Libido				
Sleep Problems				
Mood Changes or Irritability				
Tension				
Migraines or Severe Headaches				
Difficult to Climax Sexually				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry or Wrinkled Skin				
Hair Falling Out				
Cold All The Time				
Swelling All Over The Body				
Joint Pain				

History of Breast Cancer: Self (Y/N):______Family Member:_______________________________________

Have You Ever Had Any Issues With Anesthesia (Y/N):____ Explain:_________________________________

Current Hormone Replacement Therapy:____

Past Hormone Replacement Therapy:____

Nutritional Supplements or Vitamins:____

Last Menstrual Period (estimate year if known):____

Birth Control Method:____

Date of Last Mammogram:____

Date of Last Pap Smear:____

I Want to Be Sexually Active (Y/N):____________

I Have Completed My Family (Y/N):___________

History of Heart Disease (Y/N):_______________

History of Diabetes (Y/N):___________________

History of Osteoporosis (Y/N):_______________

History of Alzheimer's Disease (Y/N):_________

Male Symptom Checklist

Name:_________________________________E-Mail: ________________________________Date:_______

Symptoms (please check mark)	Never	Mild	Moderate	Severe
Decline In General Well Being				
Fatigue				
Joint Pain & Muscle Aches				
Excessive Sweating				
Sleep Problems				
Increased Need For Sleep				
Irritability				
Nervousness or Anxiety				
Depressed Mood				
Exhaustion & Lacking Vitality				
Declining Mental Focus & Concentration				
Feeling You Have Passed Your Peak				
Feeling Burned Out				
Decreased Muscle Strength				
Weight Gain, Belly Fat or Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in Beard Growth				
New Migraine Headaches				
Decreased Sexual Desire or Libido				
Decreased Morning Erections				
Decreased Ability to Perform Sexually				
Infrequent or Absent Ejaculations				
No Results From E.D. Medications				

I Smoke ________ Cigarettes or Cigars Per Day.

I Drink __________ Alcoholic Beverages Per Week.

Current Hormone Replacement Therapy:____

Past Hormone Replacement Therapy:____

Nutritional Supplements/Vitamins:____

I Am Sexually Active (Y/N) :___________________________

I Have Completed My Family (Y/N):____________________

Have You Ever Had Any Issues With Anesthesia (Y/N):____ Explain:___________________________________

History of Prostate Cancer (Y/N):_____________________