Male
Hormonal Health
Evaluation Form

Name: _____

Date: _____

FULMER 4Save PHARMACY
Professional Compounders
"Your Problem Solving Specialists"
Phone: (308) 995-6105 | Fax: (308) 995-6106

SYMPTOM CHECKLIST

Rate your current status for each symptom by circling the appropriate number. Feel free to describe any symptom you think warrants further explanation. Some symptoms are repeated to aid in our evaluation. This section may be repeated at future times.

Please use the following scale to rate each symptom below:

0 Do not have 1 2 Mild 3 4 Moderate 5 Severe

Fatigue, tiredness or loss of energy	0 1 2 3 4 5
Decrease in physical stamina	0 1 2 3 4 5
Feelings of Depression	0 1 2 3 4 5
Decreased libido - less desire for sex	0 1 2 3 4 5
Erection or potency problems	0 1 2 3 4 5
Loss of early morning erection	0 1 2 3 4 5
Dry skin on face or hand	0 1 2 3 4 5
Increased waist size	0 1 2 3 4 5
Increased fat distribution in chest area or	0 1 2 3 4 5
Feeling burned out, loss of motivation	0 1 2 3 4 5
Increase in aches, joint and muscle pains	0 1 2 3 4 5
Frequent use of alcohol - now or in the pa	0 1 2 3 4 5
Increased irritability, anger, or bad tempe	0 1 2 3 4 5
Decrease in muscle mass	0 1 2 3 4 5

The age you are: _____ The age you feel: _____

Do you experience any of the following?	Yes	No	Sometimes
Indigestion, gas, cramping			
Poor appetite, nausea, heartburn			
Constipation or diarrhea			
Diet changes for bowel integrity			
Crave sweets			
Allergies - food or environmental			
Muscle/joing cramping or soreness			
Eyes sensitive to bright light, stress			
Flashes, sparks or floaters in eyes			
Headaches			
Poor circulation, hands, feet			
Toxic metal exposure - work/living			
Emotional stress, anxiety, depression			
Parasitic or bacterial infections			
Special of Vegetarian diet			

Have you ever been treated for Prostate Cancer? Yes No

Did any medical professional ever suggest that you may have symptoms of prostate enlargement? Yes No

Please list any prescription medication that you are currently taking:

Please list any non-prescription drugs that you are taking (including vitamins, herbal products, or other supplements).

Please list any medication conditions in which you are receiving treatment:

Please list any medical conditions that you have been treated for in the past five years: