Name_____DOB_____Date_____

Testosterone:_____Baseline:_____ Follow up Peak/Trough_____

PSA_____Date_____ Hgb_____Date_____

Male AMS Questionnaire

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark "none".

Symptoms:	none	mild	moderate	severe	extremely severe
Score=	1	2	3	4	5
1. **Decline in your feeling of general well-being** (general state of health, subjective feeling).....	☐	☐	☐	☐	☐
2. **Joint pain and muscular ache** (lower back pain, pain in a limb, general back ache).....	☐	☐	☐	☐	☐
3. **Excessive sweating** (unexpected/sudden episodes of sweating, hot flashes independent of strain).....	☐	☐	☐	☐	☐
4. **Sleep problems** (difficulty in falling asleep, staying asleep, waking up early and feeling tired, poor sleep, sleepiness).....	☐	☐	☐	☐	☐
5. **Increased need for sleep, often feeling tired**.....	☐	☐	☐	☐	☐
6. **Irritability** (feeling aggressive, easily upset about little things, moody).....	☐	☐	☐	☐	☐
7. **Nervousness** (inner tension, restlessness, feeling fidgety).....	☐	☐	☐	☐	☐
8. **Anxiety** (feeling panicky).....	☐	☐	☐	☐	☐
9. **Physical exhaustion/lacking vitality** (general decrease in performance, reducing activity, lacking interest in activity, feeling of getting less done, of achieving less, of having to force oneself to undertake activities.....	☐	☐	☐	☐	☐
10. **Decrease in muscular strength** (feeling weak).....	☐	☐	☐	☐	☐
11. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings feeling nothing is of any use.....	☐	☐	☐	☐	☐
12. **Feeling that you have passed your peak**.....	☐	☐	☐	☐	☐
13. **Feeling burnt out, having hit rock-bottm**.....	☐	☐	☐	☐	☐
14. **Decrease in beard growth**.....	☐	☐	☐	☐	☐
15. **Decrease in ability/ frequency to perform sexually**.....	☐	☐	☐	☐	☐
16. **Decrease in the number of morning erections**.....	☐	☐	☐	☐	☐
17. **Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)**.....	☐	☐	☐	☐	☐
18. **Fluid retention, weight gain**.....	☐	☐	☐	☐	☐
19. **Breast pain, enlargement**.....	☐	☐	☐	☐	☐
20. **Prostate problems, urinary problems**.....	☐	☐	☐	☐	☐
21. **Memory loss, lack of concentration**.....	☐	☐	☐	☐	☐

Have you got any other major symptoms? Yes.....☐No.....☐

If Yes, please describe_____