



Men's Health Profile/Questionnaire

Patient Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email address: _____

Date of Birth: _____ Height: _____ Weight: _____

BMI (Pharmacist will calculate): _____ (BMI= Wt. in Kg/Ht. in meters²)

BMI Results for Adults Over 35:

19-26.9 Recommended

27-29.9 Overweight

30-39.9 Obese

40 (+) Morbidly Obese

Medical & Social History: Please check the following that apply to you.

High Blood Pressure

Alcohol Use

High Cholesterol

Erectile Dysfunction

Cardiovascular Disease

Insomnia

Diabetes Mellitus

Malnutrition

Osteoporosis

Depression

Benign Prostatic Hyperplasia

Cancer: _____

Tobacco Use

Other: _____

Asthma/COPD

Medication History: List all prescription and non-prescription medications that you are taking. (Include vitamins, herbals and supplements.)

Drug Allergies:

Circle Yes or No to the following questions. If yes, indicate if Mild, Moderate or Severe.

1. Do you feel more fatigued and/or tired than usual? **Yes No**
If yes, circle: **Mild Moderate Severe**

2. Have you noticed a decrease in your muscle mass? **Yes No**
If yes, circle: **Mild Moderate Severe**

3. Have you experienced a loss in muscle strength? **Yes No**
If yes, circle: **Mild Moderate Severe**

4. Have you experienced an increase in joint and/or muscle pains? **Yes No**
If yes, circle: **Mild Moderate Severe**

5. Have you noticed an increase in your waist size? **Yes No**
If yes, circle: **Mild Moderate Severe**

6. Do you have trouble losing weight? **Yes No**
If yes, circle: **Mild Moderate Severe**

7. Have you experienced a loss in height? **Yes No**
If yes, circle: **Mild Moderate Severe**

8. Do you have a decrease in your sex drive? **Yes No**
If yes, circle: **Mild Moderate Severe**

9. Have you experienced difficulty in establishing and/or maintaining full erections? **Yes No**
If yes, circle: **Mild Moderate Severe**

10. Do you have a decrease in spontaneous early morning erections? **Yes No**
If yes, circle: **Mild Moderate Severe**

11. Have you experienced changes in your usual sleep pattern? **Yes No**
If yes, circle: **Mild Moderate Severe**

12. Do you feel a decrease in your mental sharpness? **Yes No**
If yes, circle: **Mild Moderate Severe**

13. Have you had trouble concentrating? **Yes No**
If yes, circle: **Mild Moderate Severe**

14. Do you experience less enjoyment in personal interests and hobbies? **Yes No**
If yes, circle: **Mild Moderate Severe**

15. I am _____ years old. I feel _____ years old.