BHRT CHECKLIST FOR MEN

Name: ______________________ **Date:** ______________________

Email: ______________________

Symptom(s) (Please check)	**Never**	**Mild**	**Moderate**	**Severe**
☐ Decline in General Well-Being	☐	☐	☐	☐
☐ Fatigue	☐	☐	☐	☐
☐ Joint Pain/Muscle Ache	☐	☐	☐	☐
☐ Sleep Problems	☐	☐	☐	☐
☐ Increased Need for Sleep	☐	☐	☐	☐
☐ Irritability	☐	☐	☐	☐
☐ Nervousness	☐	☐	☐	☐
☐ Anxiety	☐	☐	☐	☐
☐ Depressed Mood	☐	☐	☐	☐
☐ Exhaustion/Lacking Vitality	☐	☐	☐	☐
☐ Declining Mental Ability/Focus/Concentration	☐	☐	☐	☐
☐ Feeling you have Passed your Peak, Feeling Burned Out/Hit Rock Bottom, Decreased Muscle Strength	☐	☐	☐	☐
☐ Weight Gain/Belly Fat/Inability to Lose Weight	☐	☐	☐	☐
☐ Breast Development, Shrinking Testicles, Rapid Hair Loss	☐	☐	☐	☐
☐ Decrease in Beard Growth, New Migraine Headaches, Decreased Desire/libido, Decreased Morning Erections	☐	☐	☐	☐
☐ Decreased Ability to Perform Sexually	☐	☐	☐	☐
☐ Infrequent or Absent Ejaculations	☐	☐	☐	☐
☐ No Results from E.D. Medications	☐	☐	☐	☐

Family History	**NO**	**YES**
☐ Heart Disease	☐	☐
☐ Diabetes	☐	☐
☐ Osteoporosis	☐	☐
☐ Alzheimer’s Disease	☐	☐