

MEN'S QUESTIONNAIRE /Judith Ingalls MD

Name _____ DOB _____ Date _____

- | | Yes | No |
|---|-----|-----|
| 1. Is your energy level good? | ___ | ___ |
| 2. Have you lost muscle mass or strength? | ___ | ___ |
| 3. Do you get tired with exercise? | ___ | ___ |
| 4. Are you happy with your weight? | ___ | ___ |
| 5. Are you putting weight on in the abdomen area? | ___ | ___ |
| 6. Are you happy with your primary relationship (s)? | ___ | ___ |
| 7. Do your hair and skin seem healthy? | ___ | ___ |
| 8. Do you think you have good immune function to prevent disease? | ___ | ___ |
| 9. Is your choice of foods contributing to your health? | ___ | ___ |
| 10. Do you drink 6-8 glasses of water a day? | ___ | ___ |
| 11. Have you experienced prolonged, severe stress? | ___ | ___ |
| 12. Are you sexually active? | ___ | ___ |
| 13. Are you satisfied with your sexual performance/erection? | ___ | ___ |
| 14. Do you have morning erections? | ___ | ___ |
| 15. Are you satisfied with your partner's sexual drive? | ___ | ___ |
| 16. Are you satisfied with your sexual drive? | ___ | ___ |
| 17. Do you drink more than 2 alcoholic beverages per day? | ___ | ___ |
| 18. Are you (or have you ever been) a smoker? | ___ | ___ |
| 19. Do you take drugs? | ___ | ___ |

	YES	NO
20. Do you feel depressed, anxious, or have a general loss of pleasure for life?	___	___
21. Are you irritable?	___	___
22. Do you have diminished body hair?	___	___
23. Do you exercise enough?	___	___
24. Are you happy with your mood?	___	___
25. Are you on hormones?	___	___
26. Are you on prescription medications? (list)_____	___	___
27. Are you taking over-the-counter medications? (list)_____	___	___
28. Is your sleep adequate (7-9 hours a night)?	___	___
29. Is your sleep restful?	___	___
30. Do you believe you get enough exercise?	___	___
31. Do you have chest or heart discomfort?	___	___
32. Are you physically or mentally exhausted?	___	___
33. Do you have joint pains?	___	___
34. Are you intolerant to noise?	___	___
35. Do you have recurrent illness like colds?	___	___
36. Do you have a decrease in beard or head hair growth?	___	___
37. Do you consider yourself in good health?	___	___
38. Does your health limit your physical activities?	___	___
39. Are you in pain?	___	___
40. Are your testicles smaller than they used to be?	___	___
41. Do you have trouble urinating?	___	___
42. Do you have high cholesterol , high blood pressure, or heart problems?	___	___

YES NO

43. Do you have or have you had prostate cancer? ___ ___

44. Do you have a history of low testosterone? ___ ___

45. Are you taking testosterone? ___ ___

46. Do you have sleep apnea? ___ ___

47. Do you notice a change in your mental clarity? ___ ___

48. Do you have lung disease? ___ ___

49. Do you have high cholesterol? ___ ___

50. Do you have anemia? ___ ___

51. Date of last physical exam _____ Name of Doctor _____

52. Do you have recent blood tests (if so bring them to the appointment)? ___ ___

53. What are your main concerns today that you would like to discuss with the doctor?
