Name_____ Date_____ ☐ Pre-Pellet ☐ Post Pellet

Symptom Checklist- Male

Which of the following symptoms apply at this time?
Place an "X" for EACH symptom. For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. Decline in your feeling of general well-being (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2. Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general backache)	☐	☐	☐	☐	☐
3. Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4. Sleep problems (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5. Increased need for sleep, often feeling tired	☐	☐	☐	☐	☐
6. Irritability (feeling aggressive, easily upset about little things, mood)	☐	☐	☐	☐	☐
7. Nervousness (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. Anxiety (feeling panicky)	☐	☐	☐	☐	☐
9. Physical exhaustion/lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10. Mental exhaustion/"Brain Fog" (impaired memory, foggy thinking, decrease in concentration, forgetfulness trouble coming up with words, or remembering where you left things)	☐	☐	☐	☐	☐
11. Decrease in muscular strength (feeling of weakness)	☐	☐	☐	☐	☐
12. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
13. Feeling that you have passed your peak/hit rock-bottom	☐	☐	☐	☐	☐
14. Decrease in ability/frequency to perform sexually	☐	☐	☐	☐	☐
15. Decrease in the number of morning erections	☐	☐	☐	☐	☐
16. Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐
17. Constipation (less than one bowel movement daily w ease)	☐	☐	☐	☐	☐
18. Dry skin or hair, decrease in beard growth, or hair loss	☐	☐	☐	☐	☐
19. Weight gain or inability to lose weight	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address:

Please list any prior hormone therapy:

Recent PSA: Recent Digital Rectal Exam (Date): _____ Normal / Abnormal
History of Prostate problems or Biopsy? If so, please provide details.