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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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sleep problems (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Increased need for sleep, often feeling tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Irritability (feeling aggressive, easily upset about little things, mood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Nervousness (inner tension, restlessness, feeling fidgety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Anxiety (feeling panicky)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Mental exhaustion/"Brain Fog" (impaired memory, foggy thinking, decrease in concentration, forgetfulness trouble coming up with words, or remembering where you left things)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Decrease in muscular strength (feeling of weakness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Feeling that you have passed your peak/burnt out/ hit rock-bottom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Decrease in ability/frequency to perform sexually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Decrease in the number of morning erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Constipation (less than one bowel movement daily w ease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Dry skin or hair, decrease in beard growth, or hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Weight gain or inability to lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you experiencing any unwanted effects since receiving hormone pellet therapy? If so, please describe:

Please explain anything else you want to share about your symptoms: