



Men’s Health Profile/Questionnaire

Patient Information

Name: _____ Date: _____

Address: _____

Phone: _____

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	30-39.9	Obese
27-29.9	Overweight	40 (+)	Morbidly Obese

Waist Circumference: _____ **Waist:Hip Ratio:** _____ (waist/hip)

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

- | | |
|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Malnutrition |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Benign Prostatic Hyperplasia | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> 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?
If yes, circle: Mild Moderate Severe | Yes | No |
| 2. Have you noticed a decrease in your muscle mass?
If yes, circle: Mild Moderate Severe | Yes | No |
| 3. Have you experienced a loss in muscle strength?
If yes, circle: Mild Moderate Severe | Yes | No |
| 4. Have you experienced an increase in joint and/or muscle pains?
If yes, circle: Mild Moderate Severe | Yes | No |
| 5. Have you noticed an increase in your waist size?
If yes, circle: Mild Moderate Severe | Yes | No |
| 6. Do you have trouble losing weight?
If yes, circle: Mild Moderate Severe | Yes | No |
| 7. Have you experienced a loss in height?
If yes, circle: Mild Moderate Severe | Yes | No |
| 8. Do you have a decrease in your sex drive?
If yes, circle: Mild Moderate Severe | Yes | No |
| 9. Have you experienced difficulty in establishing and/or maintaining full erections?
If yes, circle: Mild Moderate Severe | Yes | No |
| 10. Do you have a decrease in spontaneous early morning erections?
If yes, circle: Mild Moderate Severe | Yes | No |
| 11. Have you experienced changes in your usual sleep pattern?
If yes, circle: Mild Moderate Severe | Yes | No |
| 12. Do you feel a decrease in your mental sharpness?
If yes, circle: Mild Moderate Severe | Yes | No |
| 13. Have you had trouble concentrating?
If yes, circle: Mild Moderate Severe | Yes | No |
| 14. Do you experience less enjoyment in personal interests and hobbies?
If yes, circle: Mild Moderate Severe | Yes | No |
| 15. I am _____ years old. I feel _____ years old. | | |

