



Male Hormone Assessment Form

Date: _____ Name: _____

Address: _____

Phone: _____ Date of Birth: _____

The Age You Are: _____ The Age You Feel: _____ Height: _____ Weight: _____

Rate the following as they apply to you. Use the numbers 1-4, with 1 being Rare or Mild and 4 being Frequent or Severe

Symptom	Rare	Mild	Frequent	Severe
Fatigue, tiredness or loss of energy				
Decrease in physical stamina				
Feelings of depression - a sense that work, marriage or recreational activities have lost significance				
Decreased libido-less desire for sex				
Erection or potency problems				
Loss of early morning erection				
Dry skin on face or hands				
Increase in waist size - weight gain, especially around mid-section				
Increased fat distribution in chest area or hips				
Feeling burned out, loss of motivation				
Increase in aches, joints and muscle pains				
Frequent use of alcohol - now or in the past				
Increased irritability, anger or bad temper				
Decrease in muscle mass				



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What prescription medications are you taking and for how long?

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

What non-prescription medications are you taking and for how long?

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

What medical conditions are you being treated for?

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

What medical conditions have you been treated for in the past 5 years?

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

Have you ever been diagnosed with:

- 1. Prostate Cancer Yes _____ No _____
- 2. Breast Cancer Yes _____ No _____

Please provide the best telephone numbers to reach you between the hours of 9 am to 6 pm on Monday through Friday Eastern time.

To return this form:

- 1. Fax (478) 741-6559, Attention Bryan W. Scott, Pharm. D.
- 2. Mail:
One Wellness Place at Scott's Pharmacy
Attention: Bryan W. Scott, Pharm.D.
900 Gray Hwy.
Macon, GA 31211

If you have any questions, please do not hesitate to call, Bryan W. Scott, Pharm.D. at 478-741-3718