



Date: _____

Name: _____

Chart: _____

Do You Have Symptoms Of Andropause?

- | | |
|--|--|
| <input type="checkbox"/> Abdominal Fat | <input type="checkbox"/> Headaches/ Lightheaded/ Dizzy |
| <input type="checkbox"/> Aches & Pains | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Allergic Conditions | <input type="checkbox"/> Inability to Concentrate |
| <input type="checkbox"/> Anger/ Irritable | <input type="checkbox"/> Infertility Problems |
| <input type="checkbox"/> Anxious/ Anxiety | <input type="checkbox"/> Increased Urinary Urge |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Insulin Resistance/ Blood Sugar Imbalance |
| <input type="checkbox"/> Breast Enlargement | <input type="checkbox"/> Longer Recovery Time Between Orgasms |
| <input type="checkbox"/> Chronic or Autoimmune Illness | <input type="checkbox"/> Loss of Drive & Competitive Edge |
| <input type="checkbox"/> Cold Body Temperature | <input type="checkbox"/> Memory Lapses |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mental Fatigue/ Feeling Burned Out |
| <input type="checkbox"/> Decreased Beard | <input type="checkbox"/> Metabolic Syndrome |
| <input type="checkbox"/> Decreased Desire & Fantasies | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Decreased Effectiveness of Workouts | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Decreased Erectile Tension | <input type="checkbox"/> New Onset Heart Disease |
| <input type="checkbox"/> Decreased Exercise Capacity | <input type="checkbox"/> New Onset Hypertension |
| <input type="checkbox"/> Decreased Intensity of Orgasms | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Oily Skin |
| <input type="checkbox"/> Decreased Stamina | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Decreased Strength | <input type="checkbox"/> Premature Aging |
| <input type="checkbox"/> Decreased Morning Erections | <input type="checkbox"/> Shortness of Breath w/ Activities |
| <input type="checkbox"/> Decreased Muscle Mass | <input type="checkbox"/> Sleep Disturbances/ Insomnia |
| <input type="checkbox"/> Decreased Urine Flow | <input type="checkbox"/> Stiffness & Pain in Muscles & Joints |
| <input type="checkbox"/> Depressed/ Apathy | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Elevated Hemoglobin A1C levels | <input type="checkbox"/> Susceptible To Infections |
| <input type="checkbox"/> Elevated Triglycerides/ Cholesterol | <input type="checkbox"/> Swelling of Ankles/ Varicose |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Thinning Hair |
| <input type="checkbox"/> Falling Level of Fitness | <input type="checkbox"/> Thinning Sagging Skin |
| <input type="checkbox"/> Fatigue/ Lethargic | <input type="checkbox"/> "Use to could" but can't now |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Forgetfulness | |