

## 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 meters<sup>2</sup>)

### BMI Results for Adults Over 35:

19-26.9 Recommended

27-29.9 Overweight

30-39.9 Obese

40 (+) Morbidly Obese

Waist Circumference: \_\_\_\_\_ Waist:Hip Ratio: \_\_\_\_\_ (waist/hip)

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

\_\_\_ High Blood Pressure \_\_\_ Alcohol Use

\_\_\_ High Cholesterol \_\_\_ Erectile Dysfunction

\_\_\_ Cardiovascular Disease \_\_\_ Insomnia

\_\_\_ Diabetes Mellitus \_\_\_ Malnutrition

\_\_\_ Osteoporosis \_\_\_ Depression

\_\_\_ Benign Prostatic Hyperplasia \_\_\_ Cancer: \_\_\_\_\_

\_\_\_ Tobacco Use \_\_\_ Other: \_\_\_\_\_

\_\_\_ Asthma/COPD

**Medication History:** List all prescription and non-prescription medications that you are



If yes, circle: **Mild Moderate Severe**

3. Have you experienced a loss in muscle strength? **Yes No**

If yes, circle: **Mild Moderate Severe**

4. Have you experienced an increase in joint and/or muscle pains? **Yes No**

If yes, circle: **Mild Moderate Severe**

5. Have you noticed an increase in your waist size? **Yes No**

If yes, circle: **Mild Moderate Severe**

6. Do you have trouble losing weight? **Yes No**

If yes, circle: **Mild Moderate Severe**

7. Have you experienced a loss in height? **Yes No**

If yes, circle: **Mild Moderate Severe**

8. Do you have a decrease in your sex drive? **Yes No**

If yes, circle: **Mild Moderate Severe**

9. Have you experienced difficulty in establishing and/or maintaining **Yes No**  
full erections?

If yes, circle: **Mild Moderate Severe**

10. Do you have a decrease in spontaneous early morning erections? **Yes No**

If yes, circle: **Mild Moderate Severe**

11. Have you experienced changes in your usual sleep pattern? **Yes No**

If yes, circle: **Mild Moderate Severe**

12. Do you feel a decrease in your mental sharpness? **Yes No**

If yes, circle: **Mild Moderate Severe**

13. Have you had trouble concentrating? **Yes No**

If yes, circle: **Mild Moderate Severe**

14. Do you experience less enjoyment in personal interests and hobbies? **Yes No**

If yes, circle: **Mild Moderate Severe**

15. I am \_\_\_\_\_ years old. I feel \_\_\_\_\_ years old