Community Clinical Pharmacy
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Men's Health Profile/Questionnaire

Patient Information

Name: _____ Date: _____
Address:_____
Phone: _____Work phone_____Cell Phone_____
Email_____ **Drug Allergies:_____**
Date of Birth: _____ Height: _____ Weight: _____
BMI (Pharmacist will calculate): _____ (BMI= Wt. in Kg/Ht. in meters^2)

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)
Marital Status: M__, D___, W___, Single___# of biological children_____
Are you sexually active?_____
How much Alcohol do you drink? None__, Little___, Moderate___, A lot___
Do you smoke?_____
Occupation_____

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

___High Blood Pressure ___Erectile Dysfunction
___High Cholesterol ___Depression
___Cardiovascular Disease ___Insomnia
___Diabetes Mellitus ___Malnutrition
___Osteoporosis
___Benign Prostatic Hyperplasia
___Cancer: _____
___Asthma/COPD
___Surgeries_____

Medication History: List all prescription and non-prescription medications that you are taking. (Include vitamins, herbals and supplements.)

_____
_____
_____
_____
_____
_____
_____
_____

Your Dr.'s name and Phone #___ _____

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? **Yes No**
If yes, circle: **Mild Moderate Severe**

2. Have you noticed a decrease in your muscle mass? **Yes No**
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.