

# ADAM Questionnaire (Androgen Deficiency in the Aging Male)

## Patient Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_

	QUESTIONS	RARE	MILD	FREQUENT	SEVERE
1.	Do you have a decrease in libido?				
2.	Do you have a decrease in strength and/or endurance?				
3.	Do you have a lack of energy?				
4.	Have you lost some height?				
5.	Are you sad or grumpy?				
6.	Have you noticed a decreased "enjoyment of life"?				
7.	Are your erections less strong?				
8.	Have you noticed a recent deterioration in your ability to play sports?				
9.	Are you falling asleep after dinner?				
10.	Has there been a recent deterioration in your work performance?				



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Physician Copy

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Name: \_\_\_\_\_

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Answering yes to question 1 or 7, or any other 3 questions indicates a high likelihood of having a low testosterone level.

# MALE HORMONE SCREENING PANEL



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Rate the following as they apply to you. Circle the number which best applies to you, with 1 being Rare and 4 being Severe.

SYMPTOM	RARE	MILD	FREQUENT	SEVERE
Fatigue, tiredness or loss of energy	1	2	3	4
Decrease in physical stamina	1	2	3	4
Feelings of depression—a sense that work, marriage or recreational activities have lost significance	1	2	3	4
Decreased libido—less desire for sex	1	2	3	4
Erection or potency problems	1	2	3	4
Loss of early morning erection	1	2	3	4
Dry skin on face or hands	1	2	3	4
Increase in waist size-weight gain, especially around mid-section	1	2	3	4
Increased fat distribution in chest area or hips	1	2	3	4
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Feeling burned out, loss of motivation	1	2	3	4
Increase in aches, joint and muscle pains	1	2	3	4
Frequent use of alcohol—now or in the past	1	2	3	4
Increased irritability, anger or bad temper	1	2	3	4
Decrease in muscle mass	1	2	3	4

Answer the following—use the back of this page if additional room needed.

What prescription and/or non-prescription drugs are you taking (include vitamins, herbal products, or other supplements)? \_\_\_\_\_

What medical conditions are you being treated for? \_\_\_\_\_

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