

Hormone Therapy Interval Questionnaire-Male

Since your last visit or treatment answer the following:

Today's Date _____ Date of Last Treatment _____

End of week one

<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease testicular size?
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Right sided abdominal pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase snoring?
<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No Morning fatigue related to poor sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged swelling in hands and feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary difficulties?
<input type="checkbox"/> Yes <input type="checkbox"/> No Irritability?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary dribbling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase energy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease muscle fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair growth?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No Acne?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Ability to achieve erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sensitive breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile strength?	Has your primary care prescribed any new medications? If yes, list below?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile frequency?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved mental focus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved job performance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increased exercise motivation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase exercise tolerance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved moods?	
Copyright © Fox West Medical Ltd	

End of week 2

<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease testicular size?
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Right sided abdominal pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase snoring?
<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No Morning fatigue related to poor sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged swelling in hands and feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary difficulties?
<input type="checkbox"/> Yes <input type="checkbox"/> No Irritability?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary dribbling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase energy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease muscle fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair growth?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No Acne?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Ability to achieve erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sensitive breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile strength?	Has your primary care prescribed any new medications? If yes, list below?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile frequency?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved mental focus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved job performance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increased exercise motivation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase exercise tolerance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved moods?	
Copyright © Fox West Medical Ltd	

End of week 3

<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease testicular size?
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Right sided abdominal pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase snoring?
<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No Morning fatigue related to poor sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged swelling in hands and feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary difficulties?
<input type="checkbox"/> Yes <input type="checkbox"/> No Irritability?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary dribbling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase energy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease muscle fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair growth?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No Acne?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Ability to achieve erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sensitive breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile strength?	Has your primary care prescribed any new medications? If yes, list below?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile frequency?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved mental focus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved job performance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increased exercise motivation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase exercise tolerance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved moods?	
Copyright © Fox West Medical Ltd	

End of week 4

<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease testicular size?
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Right sided abdominal pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase snoring?
<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No Morning fatigue related to poor sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged swelling in hands and feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary difficulties?
<input type="checkbox"/> Yes <input type="checkbox"/> No Irritability?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary dribbling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase energy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease muscle fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair growth?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No Acne?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Ability to achieve erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sensitive breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile strength?	Has your primary care prescribed any new medications? If yes, list below?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile frequency?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved mental focus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved job performance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increased exercise motivation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase exercise tolerance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved moods?	
Copyright © Fox West Medical Ltd	

End of week 6

<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease testicular size?
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Right sided abdominal pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase snoring?
<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No Morning fatigue related to poor sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged swelling in hands and feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary difficulties?
<input type="checkbox"/> Yes <input type="checkbox"/> No Irritability?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary dribbling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase energy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease muscle fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair growth?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No Acne?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Ability to achieve erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sensitive breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile strength?	Has your primary care prescribed any new medications? If yes, list below?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile frequency?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved mental focus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved job performance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increased exercise motivation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase exercise tolerance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved moods?	
Copyright © Fox West Medical Ltd	

End of week 8

<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease testicular size?
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Right sided abdominal pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase snoring?
<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No Morning fatigue related to poor sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged swelling in hands and feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary difficulties?
<input type="checkbox"/> Yes <input type="checkbox"/> No Irritability?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary dribbling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase energy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease muscle fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair growth?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No Acne?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Ability to achieve erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sensitive breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile strength?	Has your primary care prescribed any new medications? If yes, list below?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile frequency?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved mental focus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved job performance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increased exercise motivation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase exercise tolerance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved moods?	
Copyright © Fox West Medical Ltd	

End of week 10

<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease testicular size?
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Right sided abdominal pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase snoring?
<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No Morning fatigue related to poor sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged swelling in hands and feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary difficulties?
<input type="checkbox"/> Yes <input type="checkbox"/> No Irritability?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary dribbling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase energy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease muscle fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair growth?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No Acne?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Ability to achieve erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sensitive breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile strength?	Has your primary care prescribed any new medications? If yes, list below?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile frequency?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved mental focus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved job performance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increased exercise motivation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase exercise tolerance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved moods?	
Copyright © Fox West Medical Ltd	

End of week 12

<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease testicular size?
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Right sided abdominal pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase snoring?
<input type="checkbox"/> Yes <input type="checkbox"/> No Numbness in hands?	<input type="checkbox"/> Yes <input type="checkbox"/> No Morning fatigue related to poor sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No Prolonged swelling in hands and feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary difficulties?
<input type="checkbox"/> Yes <input type="checkbox"/> No Irritability?	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary dribbling?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase energy?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No Decrease muscle fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No Increase hair growth?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No Acne?
<input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain?	<input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Ability to achieve erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No Sensitive breasts?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile strength?	Has your primary care prescribed any new medications? If yes, list below?
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase erectile frequency?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved mental focus?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved job performance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increased exercise motivation?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Increase exercise tolerance?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Improved moods?	
Copyright © Fox West Medical Ltd	