AMS Questionnaire

Patient Name: _____ Age:_____ Date:_____/_____/_____

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark "none"

Symptoms:

Please answer questions based on current symptoms today.

		none	mild	moderate	severe	extremely severe
	Score =	**1**	**2**	**3**	**4**	**5**
1.	**Decline in your feeling of general well being** (general state of health, subjective feeling).....	☐	☐	☐	☐	☐
2.	**Joint pain and muscular ache** (lower back pain, joint pain, pain in a limb, back ache).....	☐	☐	☐	☐	☐
3.	**Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes, independent of strain).....	☐	☐	☐	☐	☐
4.	**Sleep Problems** (difficulty in falling asleep, difficulty in sleeping through, waking up early/feeling tired, poor sleep, sleeplessness).....	☐	☐	☐	☐	☐
5.	**Increased need for sleep, often feeling tired**.....	☐	☐	☐	☐	☐
6.	**Irritability** (feeling aggressive, easily upset about little things, moody).....	☐	☐	☐	☐	☐
7.	**Nervousness** (inner tension, restlessness, feeling fidgety).....	☐	☐	☐	☐	☐
8.	**Anxiety** (feeling panicky).....	☐	☐	☐	☐	☐
9.	**Physical exhaustion/lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure, feeling of getting less done, having to force oneself to perform activities).....	☐	☐	☐	☐	☐
10.	**Decrease in muscular strength** (feeling of weakness).....	☐	☐	☐	☐	☐
11.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use).....	☐	☐	☐	☐	☐
12.	**Feeling that you have passed your peak**.....	☐	☐	☐	☐	☐
13.	**Feeling burnt out, having hit rock-bottom**.....	☐	☐	☐	☐	☐
14.	**Decrease in beard growth**.....	☐	☐	☐	☐	☐
15.	**Decrease in ability/frequency to perform sexually**.....	☐	☐	☐	☐	☐
16.	**Decrease in the number of morning erections**.....	☐	☐	☐	☐	☐
17.	**Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse).....	☐	☐	☐	☐	☐

Do you have any other major symptoms? **Yes.....☐** **No.....☐**

If Yes, please describe: _____

_____

18. **Date of last T-cyp injection: _____/_____/_____** **# of Days since last Injection:_____**

19. **Date of last hCG injection: _____/_____/_____** **# of Days since last Injection:_____**

20. **Time T-Cream was applied today _____:_____am/pm** **# of Days Consistent:_____**

21. **Have you ejaculated in the last 48hrs:** **Yes....☐** **No.....☐**

22. **Have you ridden a motorcycle or bicycle in the last 48hrs?** **Yes....☐** **No.....☐**

23. **What days do you take Testosterone/hCG injections?** M___ Tu___ Wed___ Th___ Fri___ Sat___ Sun___

*(mark Testosterone days with **T.** HCG days with **H**)*