Intake Questionnaire: Low-T

Name:____

Date of birth: ____

What is your medical history? ____

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Have you previously had surgery? ____

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What medications do you take? ____

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What medication allergies do you have?______________________________________

Do you smoke?____________

How many alcoholic beverages do you have in a week?____________

How often do you use recreational substances, including cannabis? ______________________

Do you experience any of the following:

Reduced lean muscle mass and increased fat storage, especially around the midsection	
Loss of libido and sexual function	
Loss of energy and motivation	
Loss of mental clarity, or “brain fog”	
Feeling fatigued, weak and tired, especially during the day	
Depression, irritability and mood swings	
Reduced sense of wellbeing	