200 E Uwchlan Ave
Exton, PA 19341
(610) 363-7474
www.lionrx.com

Men's Health Questionnaire

General Information

Name____________________________Date of Birth_______________

Address____

City____________________________State_______Zip_____________

Email____

Phone_______________________________□ Home □ Cell □ Work

Height_________Weight__________Blood type(if known)___________

Allergies____

Occupation____

Living Status □ Married □ Single □ Divorced □ Widowed

Current Health Status □ Excellent □ Good □ Fair □ Poor

Physician________________________________Phone______________

Specialty Physicians (List phone & fax number if known)

Medical History

Main symptoms and duration

____

____

____

Current Medical Conditions

➢
➢
➢
➢
➢
➢
➢
➢

Current Medications & Supplements (dosage & frequency)

➢
➢
➢
➢
➢
➢
➢
➢
➢

Family History

Relative	Important diseases	Living	Deceased
Mother			
Father			
Sister(s)			
Brother(s)			
Aunt(s)			
Uncle(s)			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Body Mass Index (BMI)

19-26.9	Recommended	30-39.9	Obese
27-29.9	Overweight	40 (+)	Morbidly Obese

Circle Yes or No to the following questions. If yes, please indicate severity

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 tone? **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/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 maintaining erections? **Yes** **No**
   If yes, circle **Mild** **Moderate** **Severe**
10. Do you have a decrease in spontaneous 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 activities? **Yes** **No**
    If yes, circle **Mild** **Moderate** **Severe**
15. I am _____ years old. I feel _____ years old.