



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

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

Have you got any major symptoms?

Yes

No

If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_





Question number	Score	Psychological Subscale	Somatic Subscale	Sexual Subscale
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
Sum of scores		Sum-score PSYCHOLOGICAL	Sum-score SOMATIC	Sum-score SEXUAL

Total sum of scores of all subscales = Total score:

