STAY FIT FOREVER

Androgen Deficiency in Aging Male (ADAM) Survey

Date of Medical Evaluation: ______ /______ / _____

Name of Patient: ______________ ________________ ___
First *Last* *MI*

Age on Day of the Exam: ____

Profession: ______________________________________

Phone Number: _____________ (888.888.8888) Email Address: ____

Primary Care Physician: _________________________

Telephone Number: ( ) -

Assessment:

		Yes	No
1.	Do you have a decrease in libido?		
2.	Do you have a lack of energy?		
3.	Do you have a decrease in strength and /or endurance?		
4.	Have you lost height?		
5.	Have you noticed a decreased enjoyment in life?		
6.	Are you sad and/ or grumpy?		
7.	Are your erections less strong?		
8.	Have you noticed a recent deterioration in your ability to play sports?		
9.	Are you falling asleep after dinner?		
10.	Has there been a recent deterioration in your work performance?		
11.	Have you noticed any diminished memory or cognitive function?		
12.	Have you noticed a decrease in the quality and quantity of sleep as you’ve aged?		
13.	Have you ever been diagnosed with sleep apnea?		