The Center for Women
Obstetrics & Gynecology
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bioTE® CERTIFIED PRACTITIONER

MALE POST PELLETING SYMPTOM ASSESSMENT CHECKLIST

Name: _____ **Date:** _____

Please mark any symptoms:

	Never	Mild	Moderate	Severe
Decline in General Well Being	( )	( )	( )	( )
Fatigue	( )	( )	( )	( )
Joint Pain & Muscle Aches	( )	( )	( )	( )
Excessive Sweating	( )	( )	( )	( )
Sleep Problems	( )	( )	( )	( )
Increased Need for Sleep	( )	( )	( )	( )
Irritability	( )	( )	( )	( )
Nervousness or Anxiety	( )	( )	( )	( )
Depressed Mood	( )	( )	( )	( )
Exhaustion & Lacking Vitality	( )	( )	( )	( )
Declining Mental Focus & Concentration	( )	( )	( )	( )
Feeling You Have Passed Your Peak	( )	( )	( )	( )
Feeling Burned Out	( )	( )	( )	( )
Decreased Muscle Strength	( )	( )	( )	( )
Breast Development	( )	( )	( )	( )
Shrinking Testicles	( )	( )	( )	( )
Rapid hair loss	( )	( )	( )	( )
Decreased in Beard Growth	( )	( )	( )	( )
New Migraine Headaches	( )	( )	( )	( )
Decreased Sexual Desire or Libido	( )	( )	( )	( )
Decreased Morning Erections	( )	( )	( )	( )
Decreased Ability to Perform Sexually	( )	( )	( )	( )
Infrequent or Absent Ejaculations	( )	( )	( )	( )
No Results from E.D. Medications	( )	( )	( )	( )
Weight Gain, Belly Fat or Inability to Lose Weight	( )	( )	( )	( )

Are you have any of the following symptoms?

	YES	NO
Nipple Sensitivity	( )	( )
Emotional	( )	( )
Acne	( )	( )
Weight Gain	( )	( )
Not losing Weight	( )	( )
Fatigue	( )	( )

SOCIAL HISTORY:

How often do you exercise (Check One)? 0 Hrs ( ) 1-3 Hrs/Wk ( ) 4-7 Hrs/Wk ( ) >8 Hrs/Wk ( )

Do you Smoke? ( ) YES ( ) NO

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