

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**AMS Questionnaire**

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:	none	mild	moderate	severe	extremely severe
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Score =	1	2	3	4	5
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 back ache).....	<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"/>
<b>Have you got any other major symptoms?</b>	Yes .....	<input type="checkbox"/>	No .....	<input type="checkbox"/>	
If Yes, please describe: _____					
_____					

THANK YOU VERY MUCH FOR YOUR COOPERATION

Recent PSA \_\_\_\_\_ Date \_\_\_\_\_ Digital rectal exam, date \_\_\_\_\_

Prior PSA's/Date \_\_\_\_\_

Please list any history of prostate problems \_\_\_\_\_

Prior hormone use \_\_\_\_\_

Baseline \_\_\_\_\_ Week 4 \_\_\_\_\_