

Chesapeake Urology Associates

Low Testosterone Questionnaire

Date: _____ Doctor: _____

Name: _____ Patient Num.: _____

ADAM Questionnaire (Androgen Deficiency in the Aging Male)

Please circle your answer to each question and return this questionnaire to Dr. David Fenig for further Low T evaluation.

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| 1. Do you have a decrease in libido (sex drive)? | Yes | No |
| 2. Do you have a lack of energy? | Yes | No |
| 3. Do you have a decrease in strength and/or endurance? | Yes | No |
| 4. Have you lost height? | Yes | No |
| 5. Have you noticed a decreased "enjoyment of life?" | Yes | No |
| 6. Are you sad and/or grumpy? | Yes | No |
| 7. Are your erections less strong? | Yes | No |
| 8. Have you had a recent deterioration in your ability to play sports? | Yes | No |
| 9. Are you falling asleep after dinner? | Yes | No |
| 10. Has there been a recent deterioration in your work performance? | Yes | No |