ANDROGEN DEFICIENCY IN THE AGING MALE (ADAM) QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Date: _____

This questionnaire is designed to help you and your doctor identify if you may be experiencing symptoms of low testosterone. If you are, you may choose to discuss treatment options with your doctor.

Please check YES or NO

	YES	NO
1. Do you have a decrease in libido (sex drive)?	___	___
2. Do you have 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 of 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 deterioration in your work performance?	___	___

The questionairre is considered positive for symptoms of low testosterone if you answered yes to either low sex drive or decreased erections, or if you answered yes to at least 3 questions in total. If positive, you should be evaluated by a Urologist to determine if treatment can improve your symptoms.