TESTOSTERONE REPLACEMENT DIARY

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Developed and printed as a service to medicine by Ardana Bioscience

This diary has been devised to help you identify any needs or problems regarding your testosterone replacement therapy during your consultation with your doctor or specialist nurse.

We hope you find it useful in organising a treatment plan tailored to your individual needs.

In order that you can keep track of your treatment we suggest that you complete this diary using a pencil.

Your name: _____

Your date of birth: _____

Your contact number: _____

Your GP: _____ Tel: _____

Your hospital doctor: _____ Tel: _____

You specialist nurse: _____ Tel: _____

What testosterone preparation are you currently taking?

Name: _____ Dose: _____

Frequency of taking it: _____

How long have you been on it? _____Year(s) ____Month(s)

Do you know the cause of your testosterone (androgen) deficiency, i.e. diagnosis? YES/NO

If YES, please specify diagnosis: _____

How long ago was this diagnosed? _____yrs

_____months

In the following six questions, please indicate whether you had experienced any of the symptoms. Please compare these symptoms before and after your testosterone treatment:

1. Reduced body hair and beard growth: YES/NO

Is this now?: **1** much better **2** better **3** the same **4** worse **5** much worse

2. Decreased or loss of libido (sex drive): YES/NO

Is this now?: **1** much better **2** better **3** the same **4** worse **5** much worse

3. Mood change, poor concentration YES/NO

Is this now?: **1** much better **2** better **3** the same **4** worse **5** much worse

4. Tiredness, low energy levels: YES/NO

Is this now?: **1** much better **2** better **3** the same **4** worse **5** much worse

5. Reduced muscle mass and strength: YES/NO

Is this now?: **1** much better **2** better **3** the same **4** worse **5** much worse

6. Reduced bone strength (osteoporosis) as indicated by the investigation called Bone Density Scan: YES/NO

Is this now?:	**1**	**2**	**3**	**4**	**5**
	much better	better	the same	worse	much worse

Please indicate on a scale of one to ten:

How informed you feel about the cause of your testosterone (androgen) deficiency:

Not at all informed **1 2 3 4 5 6 7 8 9 10** very well informed

How informed/ familiar you are with your present form of testosterone treatment:

Not at all informed **1 2 3 4 5 6 7 8 9 10** very well informed

How satisfied you are with your present form of testosterone replacement therapy:

Not at all satisfied **1 2 3 4 5 6 7 8 9 10** very satisfied

Please list any disadvantages or inconveniencies related to your current testosterone treatment:

_____

_____

_____

_____

Please list any other forms of testosterone treatment which you used before your current one:

_____

_____

_____

_____

Are you aware of any other forms of testosterone treatment which you have not yet used? Please list: _____

_____

_____

_____

Please bring this diary with you at each consultation. Please fill in the following section when you visit the clinic:

Body weight: _____ kg Height: _____ m

Please remember to ask you clinician on your testosterone level at each visit.

Normal range of testosterone for your age: _____ nmol/L

YOUR TESTOSTERONE RESULTS:

Reading	Date	Reading	Date

If you are on testosterone injections or implants, please write how many days this was done before your blood test: _____

Please make a note of any concerns or questions related to your testosterone treatment to discuss with your clinician:

_____

_____

_____

_____

_____

_____

For further information on testosterone treatment please contact:

Pituitary Foundation
PO Box 1944
Bristol
BS99 2UB

Tel: 0845 450 0375
Web Address: http://www.pituitary.org.uk
Email: helpline@pituitary.org.uk

Klinefelter's Syndrome Association UK

56 Little Yeldham Road
Little Yeldham
Halstead
Essex
CO9 4QT

Tel: 0845 230 0047
Web Address: http://www.ksa-uk.co.uk
Email: adults@ksa-uk.co.uk

Diaries are available for downloading from the Klinefelter's website.

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