



**TIER 1**  
HEALTH AND WELLNESS

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## MALE PROGRESS FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Since your last visit/blood draw have your symptoms:  
 \_\_\_\_\_ Improved \_\_\_\_\_ Deteriorated \_\_\_\_\_ Remained the same

If your symptoms have changed, please explain:

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Please check any of the symptoms that you are currently experiencing. Please check none if you are not experiencing a symptom listed:

Symptom	None	Mild	Mod	Severe
Anxiety				
Depression				
Fatigue				
Nervousness				
Sleep Disorders				
Moodiness				
Joint Pain				
Muscle Cramps				
Decreased Stamina				
Muscular Weakness				
Weight Gain				
Forgetfulness				
Headache				
Acne				

Symptom	None	Mild	Mod	Severe
Mental Fogginess				
Dry Skin				
Lack of sexual desire				
Temperature Dysregulation				
Difficulty getting an erection				
Difficulty maintaining an erection				
Feeling you have passed your peak				

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PATIENT SIGNATURE