Fanconi Anemia Registry 01
FAR01 Androgen Therapy

Patient initials |__|__|
(first name / last name)

Quarter and year of birth (q/yyyy) |__| / |__|__|__|__|

Sex: ☐ male ☐ female

Androgen therapy ☐ oxymetholone ☐ danazol ☐ other, specify I______________________I

Start date /__/__//__/__//__/__/ Stop date /__/__//__/__//__/__/

Max dose (mg/day) I___________I Current dose (mg/day) I___________I

Side effects

☐ virilization ☐ hair loss ☐ hair growth

☐ deep voice ☐ weight gain ☐ increased strength

☐ increased muscle tonus ☐ adenoma, ***please use form Adenoma***

☐ Increase AST/ALT or bilirubin

☐ growth acceleration ☐ premature growth plate closure

☐ mood changes ☐ agression ☐ depression

☐ personal rejection ☐ personal acceptance

☐ social problems ☐ priapism ☐ acne

☐ hypertension

If androgens were stopped, reasons:

☐ non-response

☐ liver adenoma

☐ liver enzyme abnormality

☐ adverse reaction, specify_______________________________________

☐ other, specify____

Further comments: ____

Referring physician name and institution I____I

Address I____I

Telephone and fax I____I

email I____I

Date I__I__II__I__II__I Signature ___________________________________