

## New Patient Intake – Male Reproductive

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**General Patient Information:** *(All information provided is held strictly confidential--see permission to share medical information section)*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status:  Single  Married  Partnered  Separated  Divorced  Widowed

Spouses Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

In case of Emergency, who should we contact?: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Reason for your visit today: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Is it getting worse? Yes No

Does it affect your: Sleep \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Are you under a physician's care now? NO YES For what? \_\_\_\_\_

**Please give us the name & phone number of your:**

Physician: \_\_\_\_\_

Urologist: \_\_\_\_\_

Reproductive Endocrinologist: \_\_\_\_\_

Reason you decided to try acupuncture & Oriental medicine? \_\_\_\_\_

How long did you think about it before you made your appointment? \_\_\_\_\_

Have you had acupuncture before? YES NO Chinese Herbal Medicines? YES NO

Surgeries: (include dates) \_\_\_\_\_

Allergies: \_\_\_\_\_

I hereby give my consent for treatment by Denise Noyer-Erez, L.Ac., and Associates.

I accept full financial responsibility for all medical services performed on my behalf.

\_\_\_\_\_  
Patient Signature

**Family Medical History:** *(Please check any and all condition(s) members of your family have had)*

<b>Illness:</b>	<b>Father</b>	<b>Mother</b>	<b>Sibling(s)</b>	<b>Grandparents</b>	<b>Aunt/Uncle</b>
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____
Drug Abuse	_____	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Strokes	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____

**General Health Information:**

Major Health Complaints and/or Symptoms:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please explain how these conditions affect or impair your daily activities:

\_\_\_\_\_

Describe your symptoms when they are at their worst:

\_\_\_\_\_

What makes your symptoms better?

\_\_\_\_\_

Are there any other complaints or conditions that you would like us to know about?

\_\_\_\_\_

Please list any non-prescription drugs or recreational drugs you currently take:

\_\_\_\_\_

**Medical Conditions/History:** *(Circle any conditions you have had, or are currently experiencing)*

Aids/HIV	Cancer	Hepatitis	Osteoporosis	Stroke
Alcoholism	Diabetes	Herpes	Pacemaker	Thyroid Disorder
Allergies	Emphysema	Lyme Disease	Pneumonia	Tuberculosis
Appendicitis	Epilepsy	High Blood Pressure	Polio	Typhoid Fever
Arteriosclerosis	Goiter	Measles	Rheumatic Fever	Ulcers
Arthritis	Gout	Menopause	Scarlet Fever	Venereal Disease
Asthma	Heart Disease	Multiple Sclerosis	Seizures	

**Reproductive History/Information:**

How long have you and your partner been trying to conceive? \_\_\_\_\_

Have you ever initiated any pregnancies in the past? \_\_\_\_\_ With IVF or IUI? \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Live births \_\_\_\_\_

Number with current partner? \_\_\_\_\_

When was the most recent pregnancy? \_\_\_\_\_

Have you been evaluated by a Reproductive Endocrinologist/Urologist? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, what was the diagnosis? \_\_\_\_\_

Have you ever had a semen analysis? \_\_\_\_\_ If yes, when? \_\_\_\_\_ (date)

Please provide the following results of the analysis

Count (million/ml) \_\_\_\_\_ Motility (%) \_\_\_\_\_

Morphology (%): Kruger \_\_\_\_\_ Volume (ml) \_\_\_\_\_

Have you ever experienced difficulty maintaining an erection? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you experienced difficulty ejaculating? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had exposure to any known environmental toxins or hormones? Yes \_\_\_\_\_ No \_\_\_\_\_

Which ones? \_\_\_\_\_

Have you ever had a sexually transmitted disease?

Chlamydia, HPV, Gonorrhea, Herpes, Other: \_\_\_\_\_

When? \_\_\_\_\_ Was it treated? \_\_\_\_\_

**Have you ever had any of the following tests or procedures?** (please check all that apply)

Test/Procedure	Date	Result	Comment
FSH	_____	_____	_____
LH	_____	_____	_____
Testosterone	_____	_____	_____
TSH	_____	_____	_____
Antisperm Antibodies	_____	_____	_____
DQ Alpha	_____	_____	_____

**Surgeries**

Vasectomy \_\_\_\_\_

Vasectomy reversal \_\_\_\_\_

Testicular biopsy \_\_\_\_\_

Varicocele ligation \_\_\_\_\_

Hernia repair \_\_\_\_\_

Undescended Testicle \_\_\_\_\_

Removal of testicle(s) \_\_\_\_\_

Other \_\_\_\_\_

**Lifestyle**

Do you use tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ # Packs/day \_\_\_\_\_

Do you use alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ # Drinks/wk \_\_\_\_\_

Do you use a hot tub? Yes \_\_\_\_\_ No \_\_\_\_\_ # times/wk \_\_\_\_\_

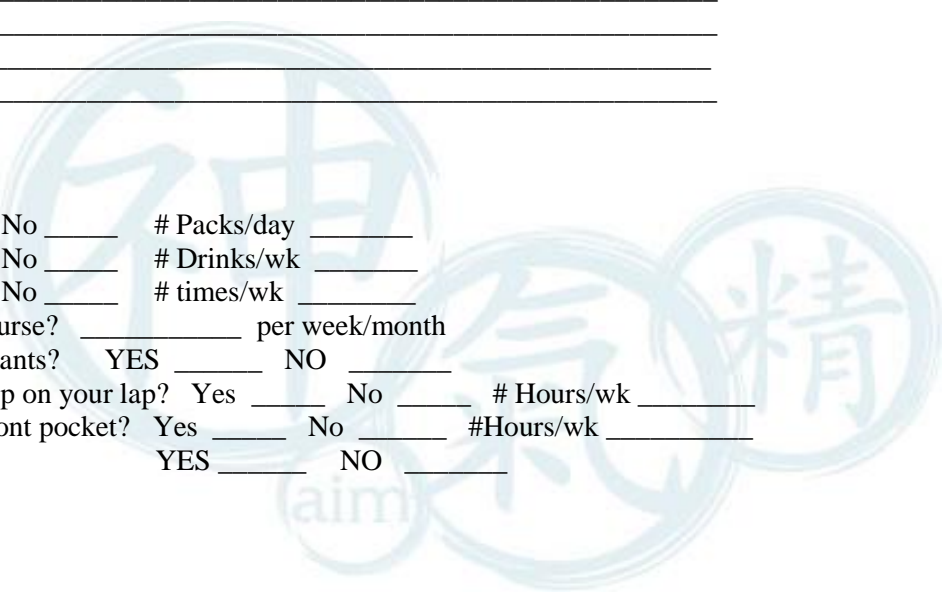
How frequently do you have intercourse? \_\_\_\_\_ per week/month

Does your partner use vaginal lubricants? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you frequently work with a laptop on your lap? Yes \_\_\_\_\_ No \_\_\_\_\_ # Hours/wk \_\_\_\_\_

Do you carry a cell phone in your front pocket? Yes \_\_\_\_\_ No \_\_\_\_\_ #Hours/wk \_\_\_\_\_

Do you have a stressful occupation? YES \_\_\_\_\_ NO \_\_\_\_\_



Medications you use currently: \_\_\_\_\_

**Overall Symptoms:** *(Please circle any of the following symptoms that currently pertain to you)*

**Body Temperature (Kidney & Organ System)**

Cold hands	Hot body temperature	Profuse perspiration
Cold feet	Cold body temperature	Lack of perspiration
Sweaty palms	Night sweating	Incontinence
Sweaty feet	Strong thirst	Night time urination

Low back weakness or pain	Dizziness
Dark circles around your eyes	Ringing in your ears
Low back pain before your period	Low libido
Feet cold, especially at night	Early morning loose stools
Premature gray hair	Colder than those around you

**Spleen Function**

Energy level: High Normal Low

Poor appetite	Feel heavy/sluggish	Energy lower after a meal
Heaviness in the head	Feel bloated after eating	Poor circulation
Crave sweets	Varicose veins	Bruise easily
Loose stools	Nose cold	
Abdominal pain	Gas	
Indigestion	Nausea	
Often sick	Hypoglycemia	

**Stomach Function**

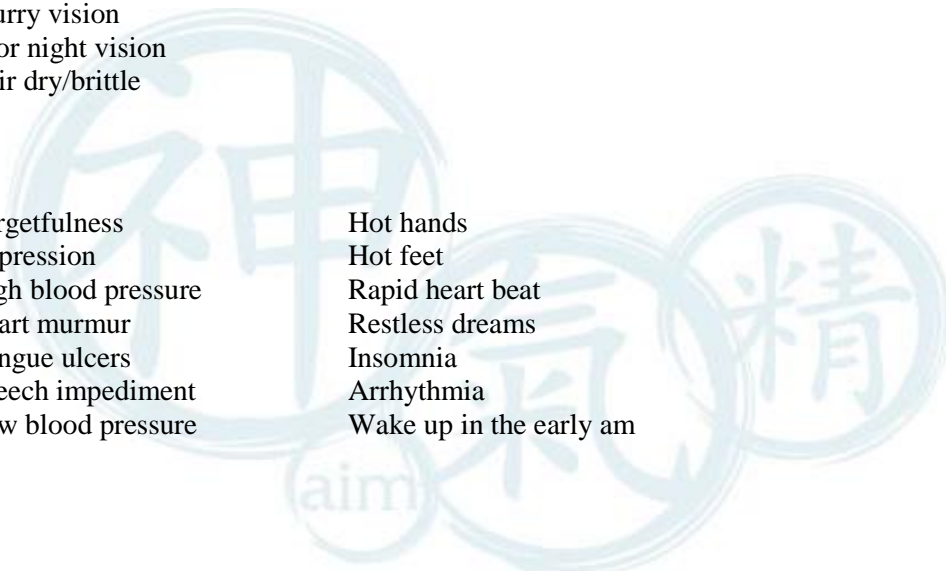
Stomachache	Stomach ulcer	Acid reflux	Heartburn
Belching	Hiccups	Mouth ulcers	Bleeding Gums
Ravenous appetite	Bad breath	Nausea	Vomiting

**Blood Function (liver, spleen, and heart system)**

Difficulty concentrating	Fainting
Dry skin	Blurry vision
Chapped lips	Poor night vision
Weak or brittle nails	Hair dry/brittle
Losing head hair	

**Heart Function**

Heart palpitations	Forgetfulness	Hot hands
Anxiety	Depression	Hot feet
Mental restlessness	High blood pressure	Rapid heart beat
Chest pain	Heart murmur	Restless dreams
Hemophilia	Tongue ulcers	Insomnia
Manic moods	Speech impediment	Arrhythmia
Severe shyness	Low blood pressure	Wake up in the early am



### **Lung Function**

Persistent cough	Chronic allergies	Dry or flaky skin
Nose bleeds	Nasal dryness	Sneezing
Difficulty breathing	Sinus congestion	Sore throats
Wheezing	Cigarette smoking	Allergies

### **Bowl Function and Elimination**

Loose stools	Constipation	Difficulty moving bowels
I.B.S or colitis	Diarrhea	Blood in stools
Small, hard, dry stools	Crohn's disease	Incomplete stools
Mucus in stools	Less than 1 BM/Day	Eating disorder

### **Accumulated Dampness**

Mental fogginess	Swollen hands	Edema in the legs
Mental sluggishness	Swollen feet	Edema in the abdomen
Poor mental focus	Joint stiffness/ache	Chest congestion
Heaviness of the head, the limbs or of the whole body		

### **Liver and Gallbladder Function**

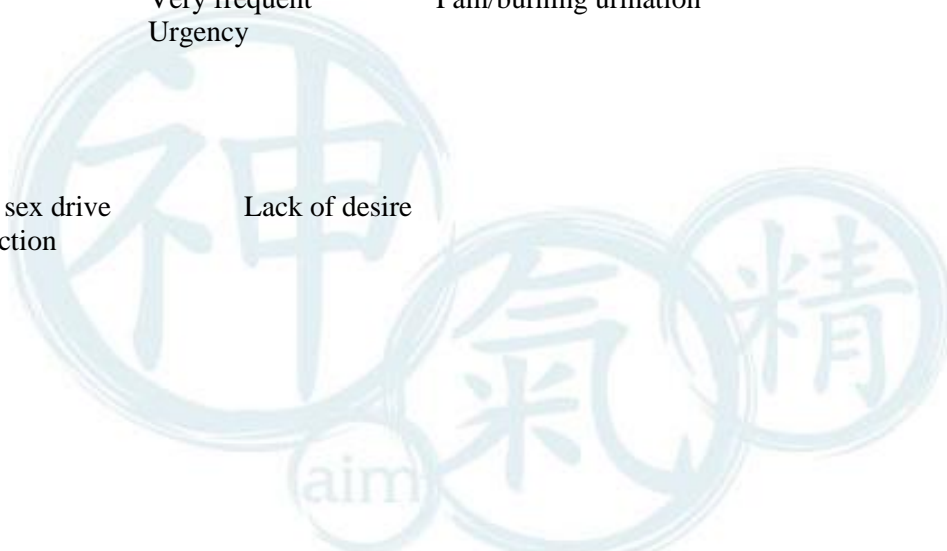
Chest pain	Irritability	Depression	Skin rashes
Chest tightness	Easy to anger	Pain in the ribcage	Acne
All over body tension	Easily frustrated	Headaches	Muscle spasms
Convulsions	Chronic neck tension	Migraines	Muscle cramps
Numbness/tingling	Shoulder tension	Gall stones	Lump in throat
Eye dryness	Seizures	Ring in the ears	
Wake with bitter taste in mouth		Difficulty falling asleep at night	
Alternating diarrhea and constipation		Easily overwhelmed by stressful circumstances	

### **Urinary Function**

Normal color	Reddish color	Small amount	Dribbling
Dark yellow	Cloudy	Large amount	UTI
Clear color	Strong odor	Very frequent	Pain/burning urination
Frequency: _____ times at night		Urgency	
_____ during the day			

### **Libido Function**

Normal	Diminished sex drive	Lack of desire
High sex drive	Sexual addiction	



**Prescription Medications & Over the Counter Medications & Supplements**

**Prescription Medications:**

Please list by name any prescription medications you are taking on a regular basis. Enter as much of the requested information as you can. The first entry serves as an example.

Product Name	Dosage	Times per day	Prescribed by	Prescribed for
Diovan HCT	80/12.5 mg	1	Dr. Smith	High Blood Pressure

**Over-the-Counter Medications and Supplements:**

Please list by name any over-the-counter medications, vitamins or other supplements you are taking on a regular basis.

Brand Name	Product Name	Dosage	Times per day	Prescribed by	What it is for
Metagenics	Ultra Meal 360 Plus	52 g	2	Dr. Lee	Diabetes

