aim acupuncture & integrative medicine

# 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)*

| Illness: | Father | Mother | Sibling(s) | Grandparents | Aunt/Uncle |
|---|---|---|---|---|---|
| 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 | |
| Dry skin | Fainting |
| Chapped lips | Blurry vision |
| Weak or brittle nails | Poor night vision |
| Losing head hair | Hair dry/brittle |

**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 | Ringing 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 |
| | | | | | |
| | | | | | |
| | | | | | |
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