



Men's Fertility Health History

Important: The information on this form will help your acupuncturist give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing, or underlying role in diagnosis and treatment of your problem.

Personal Information *(All of the information provided is strictly confidential- see permission to share medical information section)*

Name: _____ D.O.B. _____ Age: _____ Today's Date: _____
 Address: _____ City: _____
 State: _____ Zip: _____ Primary Phone: _____ Alt. Phone: _____
 Email: _____ Occupation: _____ Employer: _____
 In Case of Emergency, whom should we notify? _____ Number: _____

Primary Health Care Provider: _____ Urologist: _____

Have you been given a medical diagnosis for your condition? _____

Marital Status: Single Married Separated Divorced Widowed Partnered

Partner's Name: _____ Partner's Age: _____ Occupation: _____

Has your partner been given a fertility-related diagnosis? _____

Is your partner under the care of our clinic? Yes No

Years trying to conceive? _____

Do you have any biological children with your partner? Yes No | How many? _____ Age(s) _____

Do you have any biological children with a previous partner? Yes No | How many? _____ Age(s) _____

Medical Information

Have you had a semen analysis? Yes No | If yes, when was the most recent analysis? _____

Results for Sperm Analysis:

Date	Concentration / mL / > 20	Total Count / > 40	Motility / > 50%	Morphology > 30% / 14%	Volume (2-5 mL)

Abnormal Leukocytes / Viscosity / Liquefaction: _____

Other Notes/Comments: _____

Have you ever had any of the following Exams or Procedures?

Sperm Chromatin Structure Assay (SCSA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vasectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sperm Aspiration (MESA / TESA / PESA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anti Sperm Antibodies (ASA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	IVF with ICSI	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vasectomy Reversal	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you have any of the following symptoms either currently or in the past?

Irritable Bowel (IBS) or Crohn's	<input type="checkbox"/> Yes <input type="checkbox"/> No	Testicular Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of the testicles / scrotum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cloudy Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sensation of heat in the testicles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypospadias	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty ejaculating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retrograde Ejaculation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Erectile Dysfunction (ED)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Impotence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Testicular / scrotal itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicocele	<input type="checkbox"/> Yes <input type="checkbox"/> No
Poor or no sense of smell	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epididymitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No

History of sexually transmitted disease (STD): _____

Genetic or chromosomal abnormalities / translocations: _____

Current supplements and/or medications: _____

General Health Information

Do You Exercise Regularly? Y / N If so, what forms of exercise? _____

Major Health Complaint(s). Other than your primary reproductive concerns, please list any health concerns or complaints that you have in order of their significance.

Major Health Complaints / Symptoms

Additional Health Complaints / Symptoms

- 1. _____
- 2. _____
- 3. _____
- 4. _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____

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

Describe your symptoms when they are at their worst: _____

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

Medical Conditions and History: Check any conditions you currently have or have had in the past.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding/Hemorrhage |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV | <input type="checkbox"/> ChickenPox/Shingles | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> High Fever | <input type="checkbox"/> Polio | <input type="checkbox"/> Auto Immune Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney disease | Other: |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> High Cholesterol | | |

Please check any of the following **symptoms** that currently pertain to you (if you have symptoms in the following categories, it indicates that you may have a problem with that organ's function; this information will assist with your Chinese Medicine diagnosis.)

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Hot body temperature | <input type="checkbox"/> Profuse | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Night time urination |
| <input type="checkbox"/> Sweaty palms | <input type="checkbox"/> Afternoon flushing | <input type="checkbox"/> Night sweating | |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Strong thirst | |

Energy and Stamina (Lung and Kidney System)

- | | | | |
|--|-----------------------------------|---|------------------------------------|
| <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Easily prone to illness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sweating | <input type="checkbox"/> Frequent colds/flu/sinususes | <input type="checkbox"/> Allergies |

Blood Function (Liver, Heart and Spleen System)

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling in extremities | <input type="checkbox"/> Itchy or dry | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Weak or brittle nails |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fainting | |

Heart Function

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Manic moods | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Tongue ulcers |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Restless dreams | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Speech impediment |
| <input type="checkbox"/> Mental restlessness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression | <input type="checkbox"/> Severe shyness |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rapid Heart Beating | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral valve prolapse |

Lung Function

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Chronic allergies | <input type="checkbox"/> Dry or flaky skin | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Nasal dryness | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Cigarette smoking |

Allergies to:

- Mold Cedar Pet fur Dust Pollen Oak Hay Fever Environmentally Sensitive

If you are a smoker, # of cigarettes per day _____ How long have you been smoking? _____

If you are a smoker, do you want to quit? Yes No [Level of determination to quit - 1 2 3 4 5 6 7 8 9 10]

Spleen Function

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Low or weak appetite | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Gurgling in intestines | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Gas | <input type="checkbox"/> Fatigue following a meal | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Strong food cravings | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Indigestion |

Stomach Function

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Stomach ache | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Belching | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Mouth ulcers |

Bowel Function and Elimination (Intestinal Function)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Constipation | <input type="checkbox"/> I.B.S. or Colitis | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Small, hard, dry stools | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Incomplete stools | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Less than 1 BM/ Day | <input type="checkbox"/> Eating Disorder |

Accumulated Dampness

- | | | |
|---|--|---|
| <input type="checkbox"/> Mental foginess | <input type="checkbox"/> Swollen hands | <input type="checkbox"/> Edema in the legs |
| <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Swollen feet | <input type="checkbox"/> Edema in the abdomen |
| <input type="checkbox"/> Poor mental focus | <input type="checkbox"/> Joint stiffness / ache | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> Heaviness of the head,
the limbs, or of the
whole body | <input type="checkbox"/> Symptoms worsen
in rainy weather | |

Liver and Gall Bladder Function

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Easy to anger | <input type="checkbox"/> Pain in the ribcage | <input type="checkbox"/> Acne |
| <input type="checkbox"/> All over body tension | <input type="checkbox"/> Easily frustrated | <input type="checkbox"/> Heaviness in ribcage | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Chronic neck tension | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Numbness / tingling | <input type="checkbox"/> Shoulder tension | <input type="checkbox"/> Gall stones |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Eye pain / dryness |
| <input type="checkbox"/> Alternating diarrhea
and constipation | <input type="checkbox"/> Easily overwhelmed
by stressful circumstances | | |

Eyes (Liver Function)

- | | | | |
|--------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Grittiness | <input type="checkbox"/> Bloodshot | <input type="checkbox"/> Far sighted |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Seeing spots | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Red and irritated | <input type="checkbox"/> Near sighted | <input type="checkbox"/> Glaucoma |

Kidney and Urinary Bladder Function

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Frequent cavities | <input type="checkbox"/> Weak knees | <input type="checkbox"/> Cold lower back | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Broken / loose teeth | <input type="checkbox"/> Knee soreness | <input type="checkbox"/> Cold hips / buttocks | <input type="checkbox"/> Early graying of hair |
| <input type="checkbox"/> Weak bones | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Cold knees | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Quick to fear / fright |

Urinary Function

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Reddish color | <input type="checkbox"/> Small amount | <input type="checkbox"/> Night-time urination |
| <input type="checkbox"/> Dark Yellow | <input type="checkbox"/> Cloudy | <input type="checkbox"/> Large amount | <input type="checkbox"/> UTI / Pain or burning |
| <input type="checkbox"/> Clear color | <input type="checkbox"/> Strong odor | <input type="checkbox"/> Very frequent | <input type="checkbox"/> Hesitancy |
| <input type="checkbox"/> Difficulty initiating
the stream of urination | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Weak stream | |

Libido Function

- | | | | |
|--|---|---|------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> High sex drive | <input type="checkbox"/> Diminished sex drive | <input type="checkbox"/> DED |
| <input type="checkbox"/> Pain with ejaculation | <input type="checkbox"/> Fatigue following
sexual activity | <input type="checkbox"/> Infertility | |

Fertility Stress Assessment

Managing stress effectively is an essential component of healthy reproduction. The more effectively stress is managed, the more your body and mind become relaxed, receptive and fertile.

Is your job stressful, or fast paced? Y / N

How would you rate your current stress level? (1 being the least, 10 being the highest) 1 2 3 4 5 6 7 8 9 10

In what areas of your life do you feel the most stressed? Circle all that apply: Fertility process - Job/Career Partner/Spouse relationship - Parents/Family - Financial - Friends - Other(s): _____

How does this stress impact your:

Health: _____

Thoughts about self: _____

Thoughts about others: _____

Feelings/Mood: _____

Actions: _____

How would you describe your current level of hopefulness towards attaining your fertility goals?

(1 being the lowest feeling of hope, and 10 being the most hopeful) 1 2 3 4 5 6 7 8 9 10

What are your main source(s) of support? Spouse/Partner - Family - Friends - Workplace - Church Support group - Therapist - God/Prayer - Myself (I primarily rely on myself alone to deal with difficult issues)

Are you using any of the following methods of relaxation and/or healing? Massage therapy - Physical exercise Meditation - Prayer - Yoga - Guided imagery - Energy Work - Others: _____

Medical Evaluation

I was evaluated by a physician, OB/GYN, reproductive endocrinologist, or chiropractor for the condition(s) being treated within the last 12 months.
Yes No
I recognize that I should be evaluated by a physician for the condition(s) being treated by the acupuncturist.
Yes No

Permission to maintain medical privacy and share medical information

All of the information that you provide to us is strictly confidential. It is our policy never to disclose any personal or medical information about any patients under our care without first obtaining your express permission to do so. There are, however, a few instances where we feel that sharing information about your case helps to provide the best possible clinical outcome, and we would like to ask your permission to share information as follows.

1) Many of our patients are under the care of a Physician, a Reproductive Endocrinologist, Urologist, or a Fertility Specialist. In an effort to maximize your clinical results, we may want to contact your Doctor(s), and send them periodic updates about your case and your progress. Do you grant your permission for us to discuss the details of your case with your Physician, Reproductive Endocrinologist, Urologist, and/or Fertility Specialist?
 Yes No

Patient Signature

Date

Informed Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, cold laser, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage, organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in some doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand that the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Any appointment missed, late cancelled, or changed without 24 hours notice will result in a charge equal to 100% of the reserved service amount. The appointment may be taken off of a contract/plan or charged individually.

Patient Name (please print)

Patient Signature

Date

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

For more information please visit our website at

www.tmb.state.tx.us

AVISO SOBRE LAS QUEJAS

Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Si necesita ayuda para presentar una queja, llame al:

1-800-201-9353

Para obtener más información, visite nuestro sitio web en

www.tmb.state.tx.us