

Acupuncture • Herbal Medicine • Massage • Yoga *and so much more!*

Kali Sampson Alexander, LAc, MTOM

4307 S. Crenshaw Blvd.

Los Angeles, CA 90008

323.295.6887 or 323.29.LOTUS

**MEN'S HEALTH FORM**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*By providing complete and detailed information of your health history, you help to **significantly** increase positive outcomes in your treatment. Answer all questions even if you have encountered the same or similar questions in this or previous forms. Complete this questionnaire as thoroughly as possible. Print all information and indicate areas that you are unclear about with a question mark. Leave blank areas marked "ACUPUNCTURIST USE ONLY."*

Do you have or experience any of the following?

- Low sperm motility  Yes  No  Don't know
- Low testosterone levels  Yes  No  Don't know
- Ringing in your ears (tinnitus)  Yes  No  Don't know
- Dizziness  Yes  No  Don't know
- Low back pain or soreness  Yes  No
- Premature gray hair (before age 30)  Yes  No
- Hair loss or thinning hair  Yes  No
- Ringing in ears/tinnitus  Yes  No
- Knee pain or soreness  Yes  No
- Cold lower extremities  Yes  No
- Low sex drive  Yes  No
- Poor erectile function  Yes  No
- Aversion to cold  Yes  No
- Coldness in scrotum  Yes  No
- Lack of ejaculation  Yes  No
- Scanty ejaculation  Yes  No

Do you wake at night to urinate?  Yes  No

How many times? \_\_\_\_\_

Is your urination:

- long?  Yes  No
- clear?  Yes  No
- urgent?  Yes  No
- cloudy?  Yes  No

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**ACUPUNCTURIST USE ONLY** K+ xu P: deep, slow DC t: thick white

Do you have or experience any of the following?

- Low sperm count  Yes  No  Don't know
- Poor sperm liquefaction  Yes  No  Don't know
- Irritability  Yes  No
- Restlessness  Yes  No
- Hypertension  Yes  No
- Insomnia  Yes  No
- Premature gray hair (before age 30)  Yes  No
- Hair loss or thinning hair  Yes  No
- Impaired memory  Yes  No
- Warm at night  Yes  No
- Night sweats  Yes  No
- Heat episodes  Yes  No
- Ringing in ears/tinnitus  Yes  No
- Is your urination:
  - Frequent  Yes  No
  - Scanty  Yes  No
  - Yellow  Yes  No

**ACUPUNCTURIST USE ONLY** K-xu P: weak, fine, rapid T:red,scanty coat

Indicate if you have or experience the following:

- Prostatitis (Inflammation of the prostate gland)  Yes  No  Don't know
- Pain in lower abdomen and loins  Yes  No
- Phlegm in throat  Yes  No
- Dark yellow urination  Yes  No
- Burning urination  Yes  No
- Painful urination  Yes  No
- Frequent urination  Yes  No
- Cloudy urination  Yes  No

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Penile discharge  Yes  No

Do you have or ever been diagnosed with any of the following? If yes, indicate year and treatment, if any, received.

Genital warts  Yes  No Year: \_\_\_\_\_ Treatment: \_\_\_\_\_

\_\_\_\_\_ Herpes  Yes  No Year: \_\_\_\_\_ Treatment: \_\_\_\_\_

\_\_\_\_\_ Chlamydia  Yes  No Year: \_\_\_\_\_ Treatment: \_\_\_\_\_

\_\_\_\_\_ Yeast  Yes  No Year: \_\_\_\_\_ Treatment: \_\_\_\_\_

\_\_\_\_\_ Urinary Tract Infection (UTI)  Yes  No Year: \_\_\_\_\_ Treatment: \_\_\_\_\_

**ACUPUNCTURIST USE ONLY** LJ DH P: bowstring, slippery, rapid T: thick yellow

Do you have or experience any of the following?

Low normal sperm morphology  Yes  No  Don't know

Seminal duct blockage  Yes  No  Don't know

Swollen scrotum  Yes  No

Falling and painful testicles  Yes  No

Difficulty or inability reaching sexual climax  Yes  No

Pain upon reaching sexual climax  Yes  No

Varicocele  Yes  No

High stress level  Yes  No

Headaches  Yes  No

**ACUPUNCTURIST USE ONLY** Qi & Xue Yu T:wiry P:Dark

Have you been sexually active within the past 6 months  Yes  No

Have you had a prostate exam? Yes  No Year: \_\_\_\_\_ What were the finding? \_\_\_\_\_

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Have you had any genito-urological surgeries?  Yes  No If yes, what procedure(s) were performed ?  
\_\_\_\_\_ Complications?  Yes  No

Have you ever been diagnosed Benign Prostatic Hypertrophy (BPH)?  Yes  No If yes, when and what treatment did you or are you receiving?  
\_\_\_\_\_

Was treatment successful?  Yes  No

Have you ever been diagnosed with Prostate Cancer?  Yes  No If yes, when and what treatment did you or are you receiving? \_\_\_\_\_

Was treatment successful?  Yes  No Complications?  Yes  No

Have you ever been diagnosed with Testicular Cancer?  Yes  No If yes, when and what treatment did you or are you receiving? \_\_\_\_\_

Was treatment successful?  Yes  No

Have you ever had any other genito-urological diseases?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever tested positive for HIV/AIDS?  Yes  No

If yes, are you currently receiving treatment?  Yes  No What treatment are you receiving? \_\_\_\_\_

Have you ever taken corticosteroids?  Yes  No Year: \_\_\_\_\_ Which ones? \_\_\_\_\_

Have you ever taken anabolic steroids?  Yes  No Year: \_\_\_\_\_ Which ones? \_\_\_\_\_

Have you ever taken hormones? Yes  No Year: \_\_\_\_\_ Which ones? \_\_\_\_\_

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What medications, herbs, or supplements are you currently taking and for what conditions?

Medication, Herb, and/or Supplement	Frequency and Dosage	As a treatment for what condition?
1		
2		
3		
4		
5		

Are there any men's health concerns that were not addressed in this questionnaire? If so, please use the space below to explain.

