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MEN'S HEALTH FORM

Patient Name: _____

Date: _____

*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

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

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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

Lotus on the Nile



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
- Penile discharge Yes No

WELLNESS CENTER

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: _____

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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? _____

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

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Patient Name: _____ Date: _____

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? _____

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 or the back of this page to explain.