Male Infertility

Referring Doctor: _____ Date:__/_____/ 201__

Reason for Visit: ☐ Evaluation ☐ Herb formula ☐ Acupuncture ☐ Other_____

Name: (First) _____ (Middle) ___ (Last) _____
Date of Birth (MM/DD/YY) ___/___/___ Age___ Occupation ____
Address:_____ City: _____ State: ____ ZIP: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( )_____
Email: _____ [ ] I agree to receive the notice or information by E-Mail

PART I: MALE PARTNER MEDICAL HISTORY

- Reason for Visit: ☐ Evaluation ☐ Herb formula ☐ Acupuncture ☐ Other_____
- How many months have you been trying to conceive? _____
- Have you previously conceived with another woman?
  ☐Yes: How many times?_____ ☐No: Birth control used? Yes___ No___
- Have any of your immediate family members had difficulty conceiving a child? ☐Yes: How many of them?_____ ☐No
- What's your plan for infertility in next one year?
  ☐ By natural way: ☐1-3 months ☐4-6 months☐7-12 months ☐ more than 12 months
  ☐ By IUI: ☐1-3 months ☐4-6 months☐7-12 months ☐ more than 12 months
  ☐ By IVF: ☐1-3 months ☐4-6 months☐7-12 months ☐ more than 12 months
- ☐ Other :_____

Do you ever have the following issue (If yes, check it : X)	**If Yes, Describe it**
☐ Fathered any pregnancies in the past	_____
☐ Evaluated by a urologist	_____
☐ Infertility in previous	_____
☐ Semen analysis performed	_____
☐ Decreased Count	_____
☐ Decreased Motility	_____
☐ Abnormal Forms	_____
☐ Hormone studies performed	_____
☐ Urology evaluation in the past	_____
☐ Varicocele surgery	_____
☐ Hormonal or antibiotic treatment	_____
☐ Inseminations with your sperm	_____
☐ Inseminations with donor sperm	_____
☐ Difficulty with erection / ejaculation	_____
☐ Discomfort with ejaculation	_____
☐ Previous sterilization	_____
☐ Sterilization reversal	_____
☐ Decreased sex drive	_____
☐ Prostrate problem / infection	_____
☐ Sexually Transmitted	_____
☐ Hepatitis or HIV	_____
☐ Exposure to STD / Hepatitis / HIV	_____
☐ Mumps involving the testicles	_____
☐ Significant injury to testicle	_____
☐ Undescended testicle	_____

- ☐ Failure of testicles to develop
- ☐ Previous pelvic / groin surgery
- ☐ Unconscious from head injury
- ☐ Diabetes or other hormone disorders
- ☐ Significant illness in last 5 years
- ☐ Prolonged exposure to high heat
- ☐ Possible toxic exposures
- ☐ Cigarette smoking
- ☐ More than occasional alcohol intake
- ☐ Past / present recreational drug use
- ☐ Previous partner who used drugs
- ☐ Diseases known to be passed
- ☐ Genetically to children
- ☐ Infants born with birth defects
- ☐ Mental retardation
- ☐ Repeat miscarriages
- ☐ Cystic Fibrosis
- ☐ Tay Sachs
- ☐ Sickle Cell Disease
- ☐ Hormone disorders
- ☐current medications
- ☐ Diabetes Mellitus
- ☐ Aallergic to any medications?
- ☐scrotal or testicular pain
- ☐ Cancer
- ☐ Chemotherapy for cancer?
- ☐ Multiple Sclerosis
- ☐ Prostatic infections
- ☐ Vasectomy?
- ☐ Other neurologic
- ☐ Urinary infections
- ☐ Hernia surgery?
- ☐ Bladder or penis surgery
- ☐ mumps after puberty?
- ☐ Other

PART II: MALE PARTNER HOBBY

Diet: What percentage of your diet:

Vegetables___	Fruits___	Whole grains___	Beans/legumes___
Red meat___	Fish___	Poultry___	Dairy___
White flour(bread, pasta)___	Sugary Foods	Chips/ snacks___	/ Fast food___

Habits

- ☐ Caffeinated beverages (coffee, tea, soda), How many/day?_____
- ☐ Cigarettes? How many/day?_____ ☐ Quit - when?_____
- ☐ Beer - # per week_____ ☐ Wine- # per week_____ ☐ Liquor - # per week_____
- ☐ Marijuana, cocaine,....? _____
- ☐ Exercise? (Min/per day, type), _____
- ☐ Any radiation exposures other than X-rays? _____

TCM Diagnosis : MALE / FEMALE Name :_____

** If yes, please check "x" on the box.*

General Body Temperature	☐ Cold ☐ Cool ☐ Temperate ☐ Warm ☐ Hot	☐ Hot, High Fever, Sensitive To Heat ☐ Low Grade Fever in the Palm ☐ Cold, Sensitive To Cold ☐ Very Cold, Sensitive To Cold ☐ Other ____
HEAD AND BODY	☐ Headaches ☐ Dizziness ☐ Chest pain	☐ Poor Hearing ☐ Tinnitus ☐ Earaches ☐ Other ____
General	☐ Insufficient lactation ☐ Dizziness/vertigo ☐ Feel warm in afternoon ☐ Feel warm in evening ☐ Dry skin, hair, nails ☐ Hot flashes ☐ Flushed face ☐ Night sweats	☐ Deep heat in body or feet ☐ Low grade fever in PM ☐ Blurred or weak vision ☐ Heat in palm of hands ☐ Thirsty for cold drinks ☐ Numbness/tingling in hands ☐ Other ____
Energy	☐ Tired, fatigued ☐ Extreme fatigue ☐ Tired after exercising	☐ Spontaneous sweating ☐ Cold sweats ☐ Wake up and feel tired ☐ Other ____
Tongue color Fur	☐ Pink/Light Red Body ☐ Red Body ☐ Red Body ☐ Pale Body ☐ Purplish/Bluish Body ☐ Flaccid Body	☐ Thin Coat ☐ White Coat ☐ Yellow Coat ☐ Thin/No Coat ☐ Thick Coat ☐ Green Coat ☐ Other ____
Face	☐ Red ☐ Pale ☐ Only Cheeks Red	☐ Dark at some area ☐ Yellow at some area ☐ Other ____
Eyes	☐ Red ☐ Yellow ☐ Dark Circles ☐ Spots in front of eyes ☐ Poor vision	☐ Edema around eyes ☐ Blurry vision ☐ Eyestrain ☐ Dry ☐ Burning ☐ Other ____
Skin	☐ Red, Inflamed ☐ Dry skin ☐ Oily skin, body odor ☐ Spontaneous Sweat ☐ Rashes	☐ Changes in skin texture ☐ Psoriasis ☐ Boils/Cysts ☐ Acne ☐ Warts

	☐ Itching ☐ Ulcerations ☐ Eczema ☐ Hives ☐ Dandruff	☐ Color changes ☐ New/changed moles ☐ Lumps ☐ Other ____
Hair	☐ Hair loss ☐ Grey hair	☐ Changes in hair texture ☐ Other ____
Lungs	☐ Weak Cough ☐ Feeble cough ☐ Dry cough ☐ Productive cough ☐ Dry throat ☐ Catch colds easily ☐ Afternoon fever ☐ Post-nasal drip ☐ Chest congestion	☐ Profuse thick white/clear phlegm ☐ Shortness of breath, difficulty breathing ☐ Shortness of breath with exertion ☐ Difficulty breathing lying down ☐ Strong/loud cough w/phlegm ☐ Sinus discharge ☐ Sinus infections ☐ wheezing ☐ Other ____
Heart	☐ Rapid/weak Beat ☐ Weak heart ☐ Palpitation ☐ Cold limbs ☐ Blue lips	☐ Low functional energy ☐ Very rapid/strong beat ☐ Very poor blood circulation ☐ Other ____
Appetite Digestion	☐ High ☐ Very low appetite ☐ Cravings ☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Gas ☐ Bloating	☐ Hungry, but can not eat ☐ No energy to eat ☐ Food preferences ☐ Weak/slow digestion ☐ Heartburn ☐ Bad breath ☐ Other ____
Thirst	☐ High thirst ☐ Likes cold drinks ☐ Likes hot drinks ☐ Dry mouth	☐ Might/might not have low thirst. ☐ Low thirst, likes warm water. ☐ Thirsty with desire to drink ☐ Thirsty with no desire to drink ☐ Other ____
Liver	☐ Calm/relaxed ☐ Depressive ☐ Anxious ☐ Angry ☐ Irritable ☐ Stressed ☐ Grief ☐ Over thinking ☐ Fearful ☐ Depression ☐ Breast distension	☐ Bitter taste in mouth ☐ Foreign body sensation in throat ☐ Dysmenorrhea ☐ Numbness of limbs ☐ Muscle twitches ☐ Spasms of tendons ☐ Dry brittle nails ☐ Poor night vision ☐ Floaters/spots in vision ☐ Tremor, shaking ☐ Nail changes

	☐ Dizziness ☐ Flushed face ☐ Nightmares	☐ Scanty yellow urine ☐ Other ____
Stool	☐ Dry hard stool ☐ Sticky stool w/mucus,	☐ Get constipated or have diarrhea ☐ Number of bowel movements per day: ☐ Other ____
Spleen	☐ Nausea ☐ Weight gain ☐ General fatigue ☐ Prefer warm food ☐ Bloating after eating ☐ Tired after eating ☐ Weakness in limbs ☐ Chilly with cold limbs ☐ Poor appetite	☐ Aversion to greasy food ☐ Loose stool with undigested food ☐ Bleed/bruise easily ☐ Heavy menstrual bleeding ☐ Prolapsed organs ☐ Hemorrhoids ☐ Loose stools/diarrhea ☐ Other ____
Bladder	☐ Any pain or difficulty with either urination or defecation? ☐ undigested food, mucous, or blood in the stool? ☐ cloudy ☐ Other ____	☐ Dark, scant, yellow urine, Inflammation (UTI). ☐ Scant, light yellow urine, low grade UTI ☐ Copious urination, light/whitish Colored ☐ Copious, clear, frequent, usually night urination Color of the urine ☐ Clear, ☐ Yellow, ☐ Dark
Kidney	☐ Low back dull pain ☐ Knee pain ☐ Clear urine ☐ Impotence ☐ Dental problems ☐ Asthma ☐ Insomnia ☐ Tinnitus ☐ Dizziness ☐ Poor memory	☐ Frequent urination at night ☐ Bone fractures, weakness ☐ Loose stool with undigested food ☐ Difficulty inhaling a deep breath ☐ Diarrhea in early morning ☐ Night sweats/hot flashes ☐ Low back/knee pain ☐ Frequent urination ☐ Swollen ankles, legs ☐ Other ____
Reproduction	☐ Yeast, infections, cysts. ☐ Low sex drive, can't Perform	☐ Strong/excess sex drive ☐ Slightly higher sex drive, but tires easily ☐ Other ____
Menses	☐ Normal ,regular, no PMS, no cramps, no clots ☐ Short cycle ☐ Dark red ☐ Bright red ☐ Brown ☐ Scanty	☐ Dark purplish, long period or no period ☐ Long cycle, thin, light colored, delayed menstruation ☐ Clots in your period Size: ___cm ☐ Odour smell ☐ Other___
Sleep	☐ Very good	#___Hours of sleep per night

	☐ Good ☐ Bad ☐ Very bad ☐ Restless, low quality ☐ Wants To sleep a lot	☐ Likes to take naps, feels better after sleep ☐ Trouble falling asleep, symptoms worse at night ☐ Wants to sleep, groggy after sleep ☐ Frequently dream or nightmares ☐ Other ____
Energy	☐ Often feel tired ☐ Weak ☐ True weakness	☐ High level of energy, restless ☐ Exhausted. tired, cannot sleep ☐ Other ____
Emotions	☐ Sad, depressed ☐ No motivation ☐ Self esteem ☐ Angry and anxious	☐ Clinical, mental, neurological disorders ☐ Angry, anxious, agitated ☐ Less energy behind the emotion ☐ Restless all the time ☐ Other ____
Speech	☐ Loud, rapid, talks a Lot ☐ Speaks quickly ☐ Nnot loud or strong	☐ Heavy Voice ☐ Slow and weak speech ☐ Mainly "yes" or no Answers ☐ Other ____
Dampness Phlegm	☐ Sweaty hands/feet ☐ Ear discharge ☐ Nodules ☐ Cysts	☐ Foggy/sluggish thinking ☐ Difficulty getting up in morning ☐ Headaches like a band around the head ☐ Other ____

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