

TCM – Male Medical History Form

CONFIDENTIAL

Please check boxes, circle or fill in where applicable

To assist in providing you with the best possible care, please fill in this form as accurately as you can. All of the information will be kept confidential in your patient file.

Today's Date: ___/___/___
Month / Day / Year

Name: _____ / _____ / _____
Last Name First Name Middle Initial

Address: _____ / _____ / _____
Apt#, Street City Province Postal code

Phone: (home) _____ Occupation: _____

Phone: (work) _____ Birth Date: ___/___/___
Month Day Year

Phone: (cell) _____ E-mail _____

How did you hear about acupuncture and Chinese Medicine being offered at this clinic?

What concerns brought you into the clinic today:

What, if any, are your present symptoms: _____

Have you ever been treated with Traditional Chinese Medicine?

Yes: When: _____ No

Are you currently utilizing any other forms of health care?

Yes: _____ No

Are you currently taking any prescription or non-prescription drugs?

Yes: _____ No

Are you currently taking vitamins, minerals or herbs?

Yes: _____ No

Do you use the following? If so, how often?

Cigarettes: _____ Alcohol: _____

Drugs: _____ Coffee: _____

How do you rate your energy level: ___ /10 (10 being high and 0 low)

How do you rate your average stress level? (please circle one)

None Slight Moderate Severe

Is this normal for you? Yes No

Please list any physical activity (what type / how often):

Have you ever been hospitalized and /or treated for any serious condition or surgeries?

Yes No

If yes, briefly explain for what condition or reason you were hospitalized and the year in which you were hospitalized: _____

Do you have any of the following conditions or symptoms? (please check all that apply)

	Past	Present	Comments
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	_____
Stroke	<input type="radio"/>	<input type="radio"/>	_____
Heart Condition	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	_____
Circulation Problems	<input type="radio"/>	<input type="radio"/>	_____
Deep Vein Thrombosis	<input type="radio"/>	<input type="radio"/>	_____
Varicose Veins	<input type="radio"/>	<input type="radio"/>	_____
Abdominal Pains	<input type="radio"/>	<input type="radio"/>	_____
Digestive disorders	<input type="radio"/>	<input type="radio"/>	_____
Headaches	<input type="radio"/>	<input type="radio"/>	_____
Migraines	<input type="radio"/>	<input type="radio"/>	_____
Sleep Disorder	<input type="radio"/>	<input type="radio"/>	_____
Skin Problems	<input type="radio"/>	<input type="radio"/>	_____
Tumors / Cysts	<input type="radio"/>	<input type="radio"/>	_____
STI sexually transmitted infections	<input type="radio"/>	<input type="radio"/>	_____
Anemia	<input type="radio"/>	<input type="radio"/>	_____
Depression	<input type="radio"/>	<input type="radio"/>	_____
Allergies	<input type="radio"/>	<input type="radio"/>	_____
Asthma	<input type="radio"/>	<input type="radio"/>	_____
Infectious Diseases	<input type="radio"/>	<input type="radio"/>	_____

Head and Neck

- Dizziness
- Fainting
- Neck Stiffness
- Enlarged Lymph Glands
- Headaches / Migraines
- Other _____

Eyes

- Blurred vision
- Spots / Floaters
- Eye Pain
- Dry Eyes
- Poor Night Vision
- Red / burning or itchy
- Other _____

Ears

- Recurring Infections
- Earaches
- Ringing in ears
- Wax Buildup
- Reduced Hearing
- Other _____

Nose and Throat

- Bleeding Gums
- Sinus infections
- Hay Fever / Allergies
- Recurring Sore Throat
- Swollen Glands
- Hard to Swallow
- Bitter Taste in Mouth
- Canker / Mouth Sores
- Nose Bleeds
- Dry Mouth
- Frequent Thirst

Muscle and Joints

- Joint Pain
- Body Aches or Stiffness
- Muscle Weakness
- Numbness or Tingling
- Backache or Knee Pain
- Other _____

Respiratory

- Wheezing / Asthma
- Difficulty Breathing
- Chronic cough
- Coughing Phlegm
- Coughing Blood
- Frequent Colds
- Other _____

Genital / Urinary

- Pain/Itching of Genitalia
- Genital Lesions/
discharge
- Painful Urination
- Frequent Urination
- Urgent Urination
- Urinary Incontinence
- Excessive Urination
- Scanty Urination
- Blood in the Urine
- Wake up to Urinate
- Bedwetting
- Kidney Stones
- Increased Libido
- Decreased Libido
- Other _____

Cardio Vascular

- Heart Palpitations
- Rapid Heartbeat
- Chest Pain or Tightness
- Irregular Heartbeat
- Poor Circulation
- Swollen Ankles
- Edema
- Other _____

General

- Cold Hands or Feet
- Cold Nose
- Aversion to Heat
- Aversion to Cold
- Chills
- Recent Weight Changes
- Fatigue
- Poor memory

Skin

- Hives
- Rashes
- Eczema
- Psoriasis
- Acne
- Itchiness
- Dryness
- Mole or lump changes
- Spontaneous Sweats
- Hot Flushes / Fever
- Bruise Easily
- Fine Hair / Falling Out
- Nails Break Easily
- Other _____

Gastrointestinal

- Nausea
- Vomiting
- Acid Reflux / Heartburn
- Gas
- Bloating
- Abdominal Pains or
cramping
- Frequent Hiccups
- Bad Breath
- Poor Appetite
- Ravenous Appetite
- Hunger with no desire to
eat
- Loose or Soft Stools
- Constipation
- Alternate Loose
/Constipation
- Laxative Use
- Black Stools
- Blood in Stools
- Mucous in Stools
- Itchiness or Pain in Anus
- Burning Anus
- Rectal Pain
- Anal Fissures
- Hemorrhoids
- Other _____

Sleep

- Restful
- Light
- Hard to fall asleep
- Wake up easily / early
- Dream Disturbed
- Nightmares
- Heavy Sleep
- Night Sweats
- Hours of Sleep/night ____
- Other _____

Emotions

- Relaxed & Calm
- Sad
- Fearful
- Depressed
- Angry / Frustrated
- Irritated easily
- Anxious
- Stressed
- Over thinking / Worry
- Forgetful
- Manic
- Impatient
- Other _____

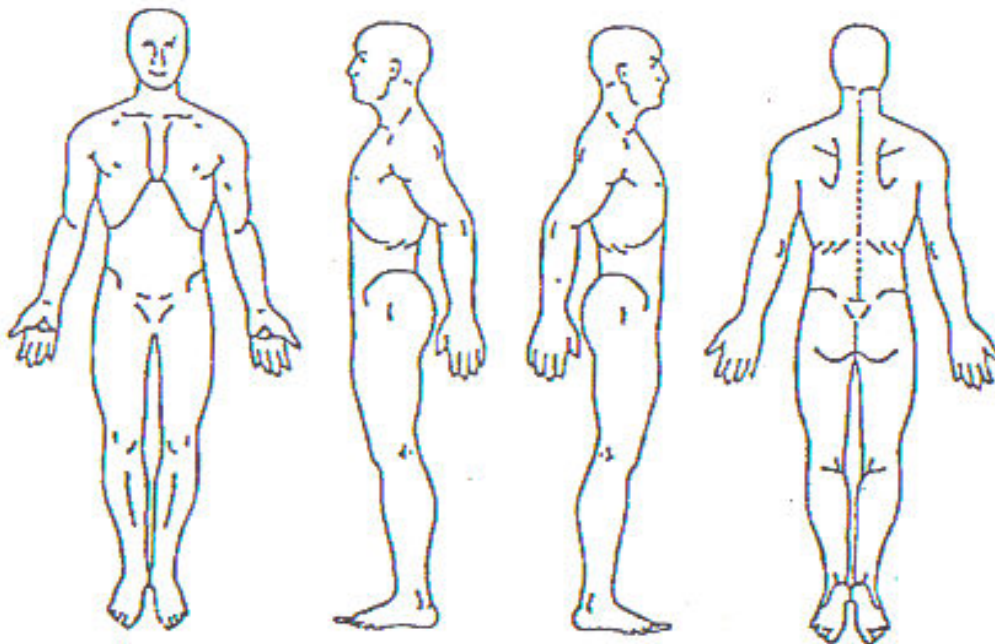
Please inform your TCM practitioner / acupuncturist if any of the following apply to you:

- | | | | |
|--|--|----------------------------------|--|
| Haemophiliac | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy | <input type="radio"/> Yes <input type="radio"/> No |
| Wear a pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Are you a vegetarian? | <input type="radio"/> Yes <input type="radio"/> No |
| Have a serious heart or lung condition | <input type="radio"/> Yes <input type="radio"/> No | Do you have surgeries scheduled? | <input type="radio"/> Yes <input type="radio"/> No |
| If you are taking anticoagulant medications? | | | <input type="radio"/> Yes <input type="radio"/> No |

Do you have Chronic or Acute injuries? Yes: _____ No

Are you currently experiencing pain? Yes: _____ No

On the figures below, Please circle any areas of pain/concern:



Sensations / pain: Sharp _____ Burning _____ Dull _____ Aching _____ Shooting _____
Tingling _____ Numbness _____ Other _____

What relieves the pain (heat/cold/massage/rest/exercise, etc.)? _____

What aggravates the pain? _____

Have you had a recent physical examination? Yes / No

Do you have high cholesterol? Yes / No

Have you recently had any prostate conditions? Yes / No

Do you have or have you ever had urinary infections or STDs? Yes / No
 Have you ever taken testosterone supplements / drugs? Yes / No
 How would you define your sexual energy? Below normal / Normal

Fertility History – fill out if applicable

Have you experienced high fever in the last 6 months? Yes / No
 Have you been checked for a blockage of your reproductive tract? Yes / No
 Do you use a hot tub? Yes / No
 Have you ever been diagnosed with a varicocele? Yes / No
 Have you ever experienced erectile dysfunction? Yes / No
 Have you experienced any penile discharge? Yes / No
 Have you been diagnosed with small or soft testis? Yes / No
 Have you had any of the following?

	Date	Result	Comment
Vasectomy			
Vasectomy reversal			
Varicocele ligaton			
Hernia repair			
Undescended testicle			
Removal of testicle(s)			
Testicular biopsy			
Testosterone level check			

Have you initiated any pregnancies in the past? Yes / No
 Number of pregnancies _____
 Number of pregnancies with current partner _____
 When was the most recent pregnancy? _____
 Have you ever had a semen analysis? Yes / No
 Result: Date _____
 Count (million cell / ml) _____
 Motility (%) _____
 Morphology (%normal forms) _____
 Other _____

Patient Advisory

During or after an acupuncture treatment certain adverse side effects, although rare, may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. No guarantees concerning its use and effects are given and you are free to refuse treatment at any time.

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or Chinese herbal substances by a licensed acupuncturist at Double Koi Acupuncture.

Signature _____ Date _____

Office Fee Policy

TCM / ACUPUNCTURE

1. Initial Consultation: \$70
2. Subsequent Visits: \$60

Missed Appointment Fee:

PATIENTS WILL BE CHARGED FOR ANY MISSED APPOINTMENTS NOT CANCELLED 24 HOURS PRIOR TO THE APPOINTMENT TIME.

Payment is due when services rendered and may be paid by cash or cheque.

Having read the statement above I fully understand and accept this fee schedule.

PATIENT'S SIGNATURE: _____ Date: _____