ACUPUNCTURE
WELLNESS CENTER LLC
EAT WELL - LIVE WELL - BE WELL

3712 MacArthur Blvd. Ste 208. New Orleans, LA 70114
Tel. 504-362-8020
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www.nolaacupuncture.com

FOR STAFF: PATIENT SHOULD COMPLETE NEW PATIENT INTAKE FORM

Male Fertility History

Patient Name: _____ **Age:** _____ **Date:** _____

Name of fertility doctor/specialist: _____ **Contact Number:** _____ **Start date:** _____

FERTILITY HISTORY

How long have you been trying to conceive with your partner: _____

Have you had any diagnosis relating to fertility: ❑ No ❑ Yes , Describe: _____

Have you had any fertility treatments: ❑ No ❑ Yes , When: _____

Type: _____

Physician: _____

Have you fathered any children: ❑ No ❑ Yes , When: _____

With your current partner: ❑ No ❑ Yes

Have you had a Semen Analysis: ❑ No ❑ Yes , Results: _____

Date: _____

Have you been examined by a urologist: ❑ No ❑ Yes , Results: _____

Have you had any microsurgery, or other operations: ❑ No ❑ Yes, For what condition: _____

Result: _____

Have you had any hormonal blood-work evaluations: ❑ No ❑ Yes, Result: _____

Have you had any other diagnostic procedures: ❑ No ❑ Yes, Type: _____

HEALTH HISTORY

At what age did you begin puberty: _____

Have you ever suffered a trauma to your reproductive organs: ❑ No ❑ Yes , When: _____

Describe: _____

Have you ever had a kidney infection: ❑ No ❑ Yes, When: _____

Have you ever had a urinary tract or bladder infection: ❑ No ❑ Yes, When: _____

Have you ever had inflammation of the prostate: ❑ No ❑ Yes, When: _____

Have you had any testicular masses or nodules: ❑ No ❑ Yes, What: _____

Have you ever had a hernia: ❑ No ❑ Yes, What: _____

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Do you have a history of undescended testes: ❑ No ❑ Yes, When did it resolve: _____

Have you had the mumps as a child: ❑ No ❑ Yes, When: _____

Was your mother exposed to DES while pregnant with you: ❑ No ❑ Yes

Have you been treated for any sexually transmitted disease: ❑ No ❑ Yes, When: _____

Describe: _____

Have you had any recent illnesses, colds or flus: ❑ No ❑ Yes, When: _____

Describe: _____

Have you been diagnosed with any other medical conditions: ❑ No ❑ Yes, When: _____

Describe: _____

LIFESTYLE

How is your sexual energy: ❑ Good ❑ Fair ❑ Low

Do you use condoms with spermicidal agents: ❑ No ❑ Yes

Do you have a very stressful job: ❑ No ❑ Yes

Are you frequently exposed to environmental toxins or pollutants: ❑ No ❑ Yes,

Describe: _____

Does your job involve sitting at a desk all day: ❑ No ❑ Yes

Do you have a stressful home environment: ❑ No ❑ Yes

Do you use recreational drugs: ❑ No ❑ Yes

Do you smoke cigarettes: ❑ No ❑ Yes

Do you drink alcohol: ❑ No ❑ Yes, How often: _____

Do you have an exercise routine: ❑ No ❑ Yes, Describe: _____

What do you do for relaxation: _____

Do you have difficulty sleeping: ❑ No ❑ Yes, Describe: _____

Are you overweight: ❑ No ❑ Yes, How many pounds: _____

Are you underweight: ❑ No ❑ Yes, How many pounds: _____

Do you struggle to maintain a consistent weight: ❑ No ❑ Yes, How so: _____

MEDICATIONS

Have you recently taken antibiotics: ❑ No ❑ Yes , When: _____

Have you ever taken steroids: ❑ No ❑ Yes , When: _____

Do you take any over the counter medications: ❑ No ❑ Yes , Type: _____

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Do you take any prescription medications: ❑ No ❑ Yes , Type: _____

Do you use any anti-fungal creams or applications: ❑ No ❑ Yes

Do you take any nutritional supplements or herbal products: ❑ No ❑ Yes , Type: _____

SYMPTOMS

Do you ever experience impotence:	❑ No	❑ Yes
Do you ever have painful erections:	❑ No	❑ Yes
Do you have difficulty sustaining an erection:	❑ No	❑ Yes
Do you ever experience nocturnal emissions:	❑ No	❑ Yes
Do you ever experience premature ejaculation:	❑ No	❑ Yes
Do you ever experience difficulty or inability to ejaculate:	❑ No	❑ Yes
Do you ever experience a loss of libido:	❑ No	❑ Yes
Do you ever feel your libido is too high:	❑ No	❑ Yes
Do you experience coldness in your scrotum:	❑ No	❑ Yes
Do you experience swelling in your scrotum:	❑ No	❑ Yes
Do you experience any pain or discomfort in your scrotum, or testes:	❑ No	❑ Yes
Do you ever have a heavy or bearing down sensation in your testicles:	❑ No	❑ Yes
Do you notice any abnormal discharge from your penis:	❑ No	❑ Yes
Do you experience genital itching:	❑ No	❑ Yes
Do you have any genital rashes or sores:	❑ No	❑ Yes
Do you have frequent urination:	❑ No	❑ Yes
Do you have interrupted urine flow:	❑ No	❑ Yes
Do you have scanty urine:	❑ No	❑ Yes
Do you have copious urine:	❑ No	❑ Yes
Is your urine generally light yellow:	❑ No	❑ Yes
Is your urine generally dark yellow:	❑ No	❑ Yes
Does your urine have a strong odor:	❑ No	❑ Yes
Does your urine feel hot:	❑ No	❑ Yes
Do you experience pain with urination:	❑ No	❑ Yes
Do you ever have slight incontinence or dribbling of urine:	❑ No	❑ Yes

OTHER COMMENTS _____

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