MALE FACTOR FERTILITY

Please take the time to fill out this history as carefully and completely as possible including dates, results, and side effects where appropriate. All of the information you provide is strictly confidential. The more information I have to work with, the better I can understand your body as a whole, and how it has responded to treatment. Thank you for taking the time to fill out this form.

Depending of where you are in your journey to conception some of the questions on this form may not apply to you. Just answer those that are relevant. Thank you!

What is your Blood Type (A, B, AB, O) ? ____

General History:

Allergies Anemia Arthritis Asthma Autoimmune Disease Diabetes Mellitus Elevated Cholesterol Fertility Issues Hepatitis Herpes High Blood Pressure Low Blood Pressure	HIV/AIDS Osteoporosis Other Cancers Pace Maker Heart Disease Scarlet Fever Sexually Transmitted Diseases Skin Cancer Thyroid Disorders Tuberculosis Urinary Incontinence Other __________________

Family History:

Alcoholism	Fertility Issues
Autoimmune Diseases	Hysterectomy
Prostate Cancers	Other Cancers
Thyroid Conditions	Osteoporosis
Diabetes	Other Cancers _____________

Date of last prostate exam: ___________ PSA results: _________

Lab results/diagnosis: ____

Frequency of urination -- daytime: ________________ night time: ___________________

Color of urine: _____________ Is urine clear or murky?: ____________ Is there any odor?: _________

	occasional	frequent		occasional	frequent
Back pain			Increased libido		
Delayed urine stream			Decreased libido		
Dribbling urine			Discharge/sores		
Incontinence			Premature ejaculation		
Retention of urine			Inability to ejaculate		
Testicular pain			Difficulty achieving erection		
Testicular masses			Difficulty sustaining erection		
Hernia			Impaired fertility		
Prostate problems			Seminal Emission		
Impotence			Premature ejaculation		
Varicocele			Chronic Pelvic Pain		
Sedentary lifestyle			Frequent Headaches		

Are you sexually active? _________________________ STDs? ____________________________

How long have you and your partner been trying to conceive? ________________
How is your sexual energy? ____
Do you have an undescended testis? _____________________________________
Have you ever been diagnosed with a varicocele? ___________________________
Have you had any urologic surgeries? ____________________________________
Have you had a vasectomy reversed? _____________________________________
Have you experienced difficulty maintaining erection? ______________________
Have you experienced difficulty ejaculating? ______________________________
Have you been exposed to any known environmental toxins or hormones? ______
Do you smoke? _______
Have you experienced any penile discharge? _______________________________
Do you regularly experience nocturnal emission? ____________________________
Have you had a fertility workup? ____

If yes, what was your sperm count? ☐ below normal ☐ normal – number ________

What was the sperm motility? ☐ below normal ☐ normal – notes____________

What was the sperm morphology? ☐ below normal ☐ normal – notes__________

Please list any prescription medications you are currently taking:

____

Please list any non-prescription medications you are currently taking, including herbs, supplements, and over-the-counter medications:

____
____

Indicate health concerns or symptoms with:1-5 (5 being the worst). Leave blank if not applicable.

WATER ELEMENT
KI/BL

- Hearing loss
- Dizziness
- Lower back ache/neck pain
- Urinary /bladder problems
- Decreased bone density
- Feel cold easily
- Reduced sex drive
- Excess sexual drive
- craving/avoiding salty foods
- Fear
- Dark under eyes
- Emotional instability
- Sinus congestion
- Oedema
- Darkness under eye
- Emotional Instability
- Aversion to cold
- hot flash/night sweating
- Hair thinning or loss
- Pre-mature aging
- Frequent urination
- Kidney Stones
- Perspire very easily
- Weakness of legs/knees
- Asthmatic cough
- Rapid weight change
- Loose teeth
- Reduced sexual energy
- Thyroid problems
- Diabetes

WOOD ELEMENT
Liv/GB

- Migraines
- Ringing in the ears
- Poor eyesight
- Eye infections
- Dry eyes
- Eczema
- Shingles
- Herpes simplex
- Warts
- Nervousness
- Convulsion, spasms, cramping
- Irritability/ anger
- Depression/stress
- Constipation
- Haemorrhoids
- Hepatitis
- Ulcer
- Vomiting
- Gallstones
- Indecisive
- Fullness below ribs
- Headaches
- Soft/brittle nails
- Poor circulation
- Emotional eater
- Clenching of teeth at night
- Shoulder/neck tension
- Insomnia 11pm-3am

FIRE ELEMENT
HT/SI

- Excess joy easily startled
- Restlessness/ agitation
- Lack of joy in life
- Dry scalp
- Insomnia/sleep problems
- Vivid dreams
- Sore throat
- Cysts, tumors
- Ear infections
- Sore throat, tonsillitis
- Lymphatic swelling
- Hot palms and soles
- Heart palpitations
- Chest pain
- Aversion to heat
- Bitter taste in mouth
- Gum problems
- Nose bleeds
- Facial redness
- Itching/burning skin
- Skin eruptions, Rashes
- Thirst
- Dark Urine
- Night sweats

OTHER

- Fatigue
- Sciatica/nerve pain
- Cold hands/feet
- Tendonitis
- Bursitis
- Fatigue
- Arthritis
- Carpal tunnel
- Numbness
- Cold hands/feet
- Bursitis/tendonitis

EARTH ELEMENT
SP/ST

- Indigestion
- Heaviness anywhere in body
- Fatigue/worse after eating
- Hard to get up in morning
- Oedema (swelling)
- Muscles feel tired often
- Easily bruising and bleeding
- Bad breath
- Decreased/increased appetite
- Crave sweets
- Hypoglycaemia
- Difficulty digesting
- Gas/belching
- Insulin sensitivity
- Abdominal pain
- Indigestion/heartburn
- Over-thinking
- Tendency to gain weight
- Brain foggy
- Food allergy
- Excess worry
- Food allergy
- Stomach ache/ulcer
- Diarrhea
- Haemorrhoids
- Constipation
- Anaemia
- Sores in mouth
- Strong appetite
- Weak Appetite
- Nausea
- Abdominal bloating
- Low body weight

METAL ELEMENT
Lu/LI

- Bronchitis SOB
- Asthma/ allergies
- Shallow breathing
- Cough/dry/phlegm
- Sinus congestion
- Nasal discharge
- Post-nasal drip
- Sinus trouble
- Itchy/red/painful
- Dry mouth/throat/nose
- Skin rashes/hives
- Snoring
- Grief/sadness
- Low resistance to colds or flu
- Sneezing
- Mild fever comes and goes
- Smoke cigarettes

FEMALE

- Painful menstrual periods
- Excessive flow
- Hot Flashes
- Irregular cycle
- Cramps or backaches
- Previous miscarriage
- Vaginal discharge
- Congested breast
- Breast Pain
- Lumps in breast
- Menopausal symptoms
- Abnormal bleeding
- Pregnancy
- Pregnancy complications

Additional Information

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____