Susan Ko, L.Ac. & Sung Kim, L.Ac.

HEALTH HISTORY for MEN

Date: ____ / ____ / _____

Name:	Sex:	Age:

Address:	City:	State:	Zip Code:

Home Phone #:	Other Phone #: Work Cell Other	Email:

Date of Birth:	Employer:	Occupation:

Primary Physician and Phone Number:

Relationship Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Living w/partner ❒ Other: _____

Emergency Contact:

Usual Blood Pressure:

Weight:

Weight One Year Ago:

How did you hear of our clinic?

Are you or may you be currently pregnant?

Have you been treated by Acupuncture or Oriental Medicine Before?

❍ No ❍ Yes: when ____/____/____

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 ——— 10

2 _____

When did this start? _____ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 ——— 10

3 _____

When did this start? _____ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 ——— 10

HEALTH HISTORY

Check the ❒ if you have / had the condition and note the year it started.
Check the ❍ if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer	❒	_____	❍
Diabetes	❒	_____	❍
Hepatitis	❒	_____	❍
High Blood Pressure	❒	_____	❍
Heart Disease	❒	_____	❍
Stroke	❒	_____	❍
Seizure Disorder	❒	_____	❍
Thyroid Disease	❒	_____	❍
Asthma	❒	_____	❍
Pacemaker	❒	_____	❍
Osteoporosis	❒	_____	❍
Herpes	❒	_____	❍
AIDS / HIV	❒	_____	❍
Other STD	❒	_____	❍
Rheumatic Fever	❒	_____	❍
Alcoholism	❒	_____	❍
Allergies type(s)?	❒	_____	❍
Mental Illness	❒	_____	❍
Kidney Disease	❒	_____	❍
Anemia	❒	_____	❍

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? ⑤ Yes ⑤ No

If so, what and how often:

_____

_____

_____

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American

Current or past eating disorder?

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

_____

_____

_____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

_____

_____

_____

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HEALTH HISTORY for MEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD — HOT

- ❒ Cold hands or feet
- ❒ Chills
- ❒ Cold "in the bones"
- ❒ Areas of numbness

Thirst for cold / hot drinks

- ❒ Thirst, no desire to drink
- ❒ Absence of thirst
- ❒ Excessive thirst

- ❒ Night sweats
- ❒ Unusual sweats
  When_____ am / pm
  Where on body _____

- ❒ Hot hands, feet, chest
- ❒ Hot flashes
- ❒ Hot in afternoon
- ❒ Hot at night

Hemorrhoids

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY — OILY

- ❒ Dry skin
- ❒ Dry hair
- ❒ Dry eyes
- ❒ Dry brittle nails

- ❒ Dry mouth
- ❒ Dry lips
- ❒ Dry throat
- ❒ Dry nose / Nosebleeds

Where on your body?

- ❒ Edema / Swelling _____
- ❒ Rashes _____
- ❒ Itching _____
- ❒ Dandruff

- ❒ Oily skin
- ❒ Oily hair
- ❒ Pimples
- ❒ Weight gain / loss

DIGESTION

DIARRHEA — CONSTIPATION

BM: How often? _____x / every _____days
Stools keep shape? ❒ Y ❒ N

- ❒ Alternating diarrhea & constipation (IBS)
- ❒ Indigestion

- ❒ Gas
- ❒ Bloating
- ❒ Belching
- ❒ Poor appetite

- ❒ Nausea / Vomiting
- ❒ Bad breath
- ❒ Heartburn
- ❒ Excessive hunger

- ❒ Dry Stools
- ❒ Difficult to pass
- ❒ Tired after BM
- ❒ Foul smelling stools

ENERGY

LOW — HIGH

- ❒ Sudden energy drop
  Time of day: _____ am / pm
- ❒ Energy drop after eating
- ❒ Fatigue

- ❒ Dependence on caffeine / stimulants
- ❒ Wired / ungrounded feeling
- ❒ Body / Limbs feel heavy
- ❒ Body / Limbs feel weak

- ❒ Shortness of breath
- ❒ Heart Palpitations
- ❒ Blood pressure High / Low
- ❒ Bleed / Bruise easy

- ❒ Hard to concentrate
- ❒ Poor memory
- ❒ Dizziness / lightheaded
- ❒ Headaches _____x / week

SLEEP

Hours per night _____

- ❒ Difficulty falling asleep
- ❒ Wake ___x/ night @_____am / pm
- ❒ Wake to urinate How often? _____
- ❒ Disturbing dreams
- ❒ Restless sleep
- ❒ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ❒ Anger
- ❒ Irritability
- ❒ Anxiety
- ❒ Worry
- ❒ Obsessive thinking
- ❒ Sadness

- ❒ Grief
- ❒ Depression
- ❒ Joy
- ❒ Fear
- ❒ Timid / shy
- ❒ Indecision

EYES, EARS, NOSE, THROAT

- ❒ Poor vision
- ❒ Night blindness
- ❒ Red eyes
- ❒ Itchy eyes
- ❒ Spots in front of eyes
- ❒ Sinus congestion
- ❒ Phlegm (color _____)

- ❒ Poor hearing
- ❒ Ringing in ears
- ❒ Excess earwax
- ❒ Sore throat
- ❒ Dental problems
- ❒ Mouth sores
- ❒ Cough

URINARY

Fluid in = fluid out? ❒ Y ❒ N

- ❒ Decrease in flow
- ❒ Dribbling
- ❒ Difficulty starting / stopping
- ❒ Incontinence
- ❒ Kidney stones

- ❒ Urgency to urinate
- ❒ Frequent urination
- ❒ Pain on urination
- ❒ Burning sensation
- ❒ Cloudy urine
- ❒ Blood in urine

REPRODUCTIVE

Are you sexually active? ❒ Y ❒ N

- ❒ Change of sexual drive: ↑ ↓
- ❒ Erectile dysfunction
- ❒ Premature ejaculation
- ❒ Sores on genitals
- ❒ Discharge

- ❒ Prostate disease
- ❒ Genital Pain
- ❒ Jock Itch
- ❒ Vasectomy
- ❒ Hernia
- ❒