



Welcome to Triangle Acupuncture Clinic. To help us provide you with the best possible care, please fill out this form carefully. All the information will be kept confidential in your patient file. If you have any questions please ask us. Thank you for your time.

Name:		Today's Date:	
Street Address:	City:	State:	Zip:
Home Phone: ( )	Work Phone: ( )	Email:	
In Case of Emergency, Contact:			
Birth Date:	How did you hear about us:		
Marital Status:	Social Security #	Occupation:	
Age:	Height:	Weight:	Sex:
Primary Physician's Name:		Date of last visit:	
Reproductive Endocrinologist's Name:		Date of last visit:	
Other Physician's You See Regularly and For What Conditions:			

**INSURANCE INFORMATION:** You may request a receipt which you can send in to your insurance company for potential reimbursement. We do not bill insurance at this time. Payment is due at the time of service.

Primary Insurance:		
Phone Number: ( )	Employer:	
Policy Holders Name:	ID Policy #:	Group #:

**PAST AND FAMILY MEDICAL HISTORY:**

Please list any major illnesses or surgeries and the date:

Do you smoke or chew tobacco? How much, how often?

Do you consume caffeine? How much, how often?

Do you consume alcohol? How much, how often?

How many glasses of water do you drink per day?

What other beverages do you consume daily: milk juice soda other

Briefly describe your diet: (use the back if necessary)

Mark an X in the box next to any of the following that you are now taking:

aspirin ☐                      diet pills ☐                      cold tablets ☐                      oral contraceptives ☐  
antacids ☐                      sleeping pill ☐                      tranquilizers ☐                      blood pressure pills ☐  
ibuprofen ☐                      fiber ☐                      laxatives ☐                      acetaminophen ☐

List all medications you are taking and amounts:

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List all vitamins & supplements:

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List Drug Allergies:

	Self	Mother	Father	Sibling	Sibling	Spouse	Child
Allergies							
Anemia							
Cancer							
Diabetes							
Drug Use							
High Blood Pressure							
Stroke							
Heart Disease							
Tuberculosis							
Depression							
Mental Illness							
Other							
Age at Death							

### Fertility History

How long have you been trying to conceive?

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Have you ever had any urologic surgeries?

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Have you experienced difficulty maintaining erection?

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Have you experienced difficulty ejaculating?

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Do you regularly experience nocturnal emission?

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Do you ever have any other penile discharge?

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Have you ever been diagnosed with a varicocele?

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Is your urination : frequent    infrequent    clear    dark yellow/concentrated    burning    other

Have you had a fertility workup? When?

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What was the sperm count?    Normal    Below Normal    #

What was the sperm motility?    Normal    Below Normal    Notes

What was sperm morphology?    Normal    Abnormal    Notes

How is your sexual energy?            Low            Normal            High

How is your relationship with your partner now?            Not Good            Stressed            Good            Awesome

Do you have a support system of friends and family?

Describe your stress level and any predominant emotions you are experiencing

What are you currently doing to promote relaxation and combat stress?

Any other thoughts or information related to your physical or emotional health that you would like to share?