



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 questions please ask us. Thank you for your time.

CONTACT INFORMATION

Name: _____ Today's Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: () _____ circle: home work cell

Secondary Phone: () _____ circle: home work cell

Circle the Best Number to Reach You: primary secondary

Email Address: _____

In Case of Emergency, Contact: _____ Phone: () _____ circle: h w c

Birth Date: _____ How did you hear about us? _____

Marital/Relationship Status: _____ Occupation: _____

Age: _____ Height: _____ Weight: _____ Sex: _____

Primary Physician's Name: _____ Date of last visit: _____

Reproductive Endocrinologist's Name: _____ Date of last visit: _____

Other Health Care Providers You See Regularly and For What Conditions: _____

FERTILITY HISTORY

How long have you been trying to conceive? _____

Have you ever had any urologic surgeries? _____

Have you experienced difficulty maintaining erection? _____

Have you experienced difficulty ejaculating? _____

Do you regularly experience nocturnal emission? _____

Do you ever have any other penile discharge? _____

Have you ever been diagnosed with a varicocele? _____

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

Have you had a fertility workup? If so, when was it? _____

What was the sperm count? normal below normal #: _____

What was the sperm motility? normal below normal notes: _____

What was the 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 do you currently do to promote relaxation and combat stress?

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

CURRENT HEALTH

How many glasses of water do you drink per day?

What other beverages do you consume daily?

Briefly describe your diet and any special diets: (use the back if needed)

Do you smoke/chew tobacco?

How much and how often?

Do you consume caffeine?

How much and how often?

Do you consume alcohol?

How much and how often?

Do you use recreational drugs?

How much and how often?

Please list all vitamins and supplements you are taking:

Please list all prescription and over-the-counter medications you are taking, dosages for each and why you are taking each: (use the back of form if more room is needed):

List any drug allergies:

PAST AND FAMILY MEDICAL HISTORY

Please list any major illnesses and operations, and the date of onset:

Please check all that apply:

	Self	Mother	Father	Sibling	Sibling	Spouse	Child
Allergies							
Anemia							
Cancer							
Diabetes							
High Blood Pressure							
Stroke							
Heart Disease							
Depression							
Mental Illness							
Hepatitis							
HIV/AIDS							
Autoimmune Disease							
Infectious Disease							
MRSA/Staff Infection							
Other							
Age at Death							

Please continue to the following forms: HIPAA, Office Policy, and Arbitration/Informed Consent (front and back)