

Patient \_\_\_\_\_ Date \_\_\_\_\_

Please answer the following questions even if you have encountered the same question in a previous form. Do not answer questions if indicated for your acupuncturist to fill. Your answers are important as they will help us determine your diagnosis and treatment plan to most effectively enhance your reproductive health.

**Kid yang xu**

Do you have or experience any of the following?

	Yes	No	Don't Know
low sperm motility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
low testosterone levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*ringing in the ears (tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*low back pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
knee pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cold lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
aversion to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
coldness in the scrotum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
low libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor erectile function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lack of ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Do have to get up in the middle of the night to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often? _____			
Is your urination long?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clear?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse-deep, slow (acupuncturist)			
Tongue – thin, white coat (acupuncturist)			

**\*Kid yin xu**

Do you have or experience any of the following?

	Yes	No	Don't Know
low sperm count	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor sperm liquefaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
restlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
impaired memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
red cheeks (malar flush) in the afternoon and early evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your urination frequent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scanty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yellow?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse - weak, fine, rapid (acupuncturist)			
Tongue - red, scanty coat (acupuncturist)			

**Damp heat blocking lower jiao**

Do you have or experience any of the following?

	Yes	No	Don't Know
prostatitis (painful condition of the prostate gland)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pain in lower abdomen and loins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
phlegm in throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Yes      No      Don't Know

Is your urination dark yellow?  
burning?  
difficult?  
painful?  
frequent?  
urgent but inhibited/hesitant?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pulse – bowstring, slippery, rapid (acupuncturist)  
Tongue – thick, slimy, yellow coat (acupuncturist)

Qi & Xue Yu

Do you have or experience any of the following?

Yes      No      Don't Know

low normal sperm morphology  
swollen scrotum  
falling & painful testicles  
seminal duct blockage  
varicocele  
high stress level

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pulse – wiry (acupuncturist)

Tongue – dark (acupuncturist)