

**LEOMINSTER ACUPUNCTURE STUDIO
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.

<p align="center">COLD</p> <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness	<p align="center">Thirst for cold / hot drinks</p> <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Excessive thirst	<p align="center">Night sweats</p> <input type="checkbox"/> Unusual sweats When _____ am / pm Where on body _____	<p align="center">HOT</p> <input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night
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MOISTURE
Your overall body moisture (hair, skin, mouth, bowels, etc.)

<p align="center">DRY</p> <input type="checkbox"/> Dry skin <input type="checkbox"/> Dry hair <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry brittle nails	<input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry lips <input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose / Nosebleeds	<p align="center">Where on your body?:</p> <input type="checkbox"/> Edema / Swelling _____ <input type="checkbox"/> Rashes _____ <input type="checkbox"/> Itching _____ <input type="checkbox"/> Dandruff	<p align="center">OILY</p> <input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss
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DIGESTION

<p align="center">DIARRHEA</p> <p>BM: How often? _____ x / every _____ days Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Indigestion	<p align="center">CONSTIPATION</p> <input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Poor appetite	<input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bad breath <input type="checkbox"/> Heartburn <input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Dry Stools <input type="checkbox"/> Difficult to pass <input type="checkbox"/> Tired after BM <input type="checkbox"/> Foul smelling stools
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ENERGY

<p align="center">LOW</p> <input type="checkbox"/> Sudden energy drop Time of day: _____ am / pm <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue	<p align="center">HIGH</p> <input type="checkbox"/> Dependence on caffeine / stimulants <input type="checkbox"/> Wired / ungrounded feeling <input type="checkbox"/> Body / Limbs feel heavy <input type="checkbox"/> Body / Limbs feel weak	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Blood pressure High / Low <input type="checkbox"/> Bleed / Bruise easy	<input type="checkbox"/> Hard to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Dizziness / lightheaded <input type="checkbox"/> Headaches _____ x / week
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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?

<input type="checkbox"/> Anger	<input type="checkbox"/> Grief
<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Joy
<input type="checkbox"/> Worry	<input type="checkbox"/> Fear
<input type="checkbox"/> Obsessive thinking	<input type="checkbox"/> Timid / shy
<input type="checkbox"/> Sadness	<input type="checkbox"/> Indecision

EYES, EARS NOSE THROAT

<input type="checkbox"/> Poor vision	<input type="checkbox"/> Poor hearing
<input type="checkbox"/> Night blindness	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Excess earwax
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Phlegm (color _____)	<input type="checkbox"/> Cough

URINARY

Fluid in = fluid out? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Urgency to urinate
<input type="checkbox"/> Decrease in flow	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Dribbling	<input type="checkbox"/> Pain on urination
<input type="checkbox"/> Difficulty starting / stopping	<input type="checkbox"/> Burning sensation
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Cloudy urine
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Blood in urine

REPRODUCTIVE

Are you sexually active? Y N

<input type="checkbox"/> Change of sexual drive: ↑ ↓	<input type="checkbox"/> Prostate disease
<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Genital Pain
<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Jock Itch
<input type="checkbox"/> Sores on genitals	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Discharge	<input type="checkbox"/> Hernia
	<input type="checkbox"/> Hemorrhoids

