



BULL CITY ACUPUNCTURE 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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Thirst for cold / hot drinks | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Hot hands, feet, chest |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Thirst, no desire to drink | <input type="checkbox"/> Unusual sweats | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold "in the bones" | <input type="checkbox"/> Absence of thirst | When _____ am / pm | <input type="checkbox"/> Hot in afternoon |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Excessive thirst | Where on body _____ | <input type="checkbox"/> Hot at night |

MOISTURE

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

DRY

OILY

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

DIGESTION

DIARRHEA

CONSTIPATION

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

ENERGY

LOW

HIGH

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

- | | |
|---|--------------------------------------|
| <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 |