



MIA 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"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Thirst for cold / hot drinks <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats <i>When _____ am / pm</i> <i>Where on body _____</i>
		<input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <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 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	<i>Where on your body?:</i> <input type="checkbox"/> Edema / Swelling _____ <input type="checkbox"/> Rashes _____ <input type="checkbox"/> Itching _____ <input type="checkbox"/> Dandruff
		<input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss

DIGESTION

DIARRHEA		CONSTIPATION
BM: How often? _____ x / every _____ days Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Indigestion	<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

ENERGY

LOW		HIGH
<input type="checkbox"/> Sudden energy drop <i>Time of day: _____ am / pm</i> <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue	<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

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"/> Irritability <input type="checkbox"/> Anxiety <input type="checkbox"/> Worry <input type="checkbox"/> Obsessive thinking <input type="checkbox"/> Sadness	<input type="checkbox"/> Grief <input type="checkbox"/> Depression <input type="checkbox"/> Joy <input type="checkbox"/> Fear <input type="checkbox"/> Timid / shy <input type="checkbox"/> Indecision
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EYES, EARS NOSE THROAT

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

Fluid in = fluid out? Y N

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

Are you sexually active? Y N

Change in Sex Drive? Y N

<input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Sores on genitals <input type="checkbox"/> Discharge <input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Prostate disease <input type="checkbox"/> Genital Pain <input type="checkbox"/> Jock Itch <input type="checkbox"/> Vasectomy <input type="checkbox"/> Hernia <input type="checkbox"/> Hemorrhoids
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