



**Manchester Acupuncture Studio, LLC**  
**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

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness

- Thirst for cold / hot drinks
- ☐ Thirst, no desire to drink
  - ☐ Absence of thirst
  - ☐ Excessive thirst

- ☐ Night sweats
  - ☐ Unusual sweats
- When \_\_\_\_\_ am / pm  
Where on body \_\_\_\_\_

- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

**MOISTURE**

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

DRY

OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry brittle nails

- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / Nosebleeds

- Where on your body?:
- ☐ Edema / Swelling \_\_\_\_\_
  - ☐ Rashes \_\_\_\_\_
  - ☐ Itching \_\_\_\_\_
  - ☐ Dandruff \_\_\_\_\_

- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss

**DIGESTION**

DIARRHEA

CONSTIPATION

- BM: How often? \_\_\_\_\_ x / every \_\_\_\_\_ days
- Stools keep shape? ☐ Y ☐ N
- ☐ Alternating diarrhea & constipation (IBS)
  - ☐ Indigestion

- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger

- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

**ENERGY**

LOW

HIGH

- ☐ Sudden energy drop
- Time of day: \_\_\_\_\_ am / pm
- ☐ Energy drop after eating
  - ☐ Fatigue

- ☐ Dependence on caffeine / stimulants
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak

- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easy

- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ 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?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

**EYES, EARS NOSE THROAT**

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (color \_\_\_\_\_)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

**URINARY**

- Fluid in = fluid out? ☐ Y ☐ N
- ☐ Decrease in flow
  - ☐ Dribbling
  - ☐ Difficulty starting / stopping
  - ☐ Incontinence
  - ☐ Kidney stones
  - ☐ Urgency to urinate
  - ☐ Frequent urination
  - ☐ Pain on urination
  - ☐ Burning sensation
  - ☐ Cloudy urine
  - ☐ Blood in urine

**REPRODUCTIVE**

- Are you sexually active? ☐ Y ☐ N
- Change of sexual drive:  $\uparrow$   $\downarrow$
- ☐ Erectile dysfunction
  - ☐ Premature ejaculation
  - ☐ Sores on genitals
  - ☐ Discharge
  - ☐ Prostate disease
  - ☐ Genital Pain
  - ☐ Jock Itch
  - ☐ Vasectomy
  - ☐ Hernia
  - ☐ Hemorrhoids