3523 MAIN ST VANCOUVER BC T: 604.873.9355 www.Yinstill.com

Andrology Intake

Date:

Last name /	First name /

Birth date /	Age /	Spouse's Name/
Address/		Phone (home)/
City /		Phone (work) /
Province /	Postal Code /	Phone (cell) /
Email /		Occupation /
Family Physician name /		Family Physician phone /

Reason for appointment (medical diagnosis if applicable):

List your main health concerns in order of importance to you:	1.	2.
	3.	4.

Please list any prescription medication or over the counter drugs currently taking:		Please list herbal medicine and other supplements currently taking:	
1.	2.	1.	2.
3.	4.	3.	4.
5.	6.	5.	6.
Please list any allergies (food, drugs, environmental, etc.):		Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).	
1.	2.		
3.	4.		
5.	6.		

Do you participate in the following physical activities? If so, please indicate how often:			
Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

Have you had Acupuncture before? Yes No	Height:	Taken antibiotics _____ times (life)
Chinese herbal medicine? Yes No	Weight:	Taken oral steroids _____ times (life)

How did you hear about Yinstill?
(Internet, Wife, Friend, Doctor, Fertility Clinic)

Do you use the following? If so how often? Cigarettes: _____ Alcohol: _____ Drugs: _____ Coffee: _____ Pop: _____

What are the personal stresses in your life?

Please print, complete, and fax or email before your initial appointment. Thank you.

ENVIRONMENTAL EXPOSURE: Have you ever been exposed to any of the following;

- Chemicals of solvents and their fumes? □Yes □No
- Temperature extremes (cold or hot)? □Yes □No
- Temperature extremes (cold or hot)? □Yes □No
- Radiation, X-rays or radio-isotopes? □Yes □No
- Medication for cancer, blood pressure, hair loss, diabetes, thyroid? □Yes □No
- Testosterone or steroids? □Yes □No

REPRODUCTIVE & SEXUAL:

- Are you currently undergoing assisted reproductive treatments? □Yes □No (PCRM, Genesis, Other)
- Have you had your semen analyzed? □Yes □No
- Have you had lab tests done (genetic, testosterone, TSH, FSH, glucose, cholesterol, etc)? □Yes □No
- Do you have a low libido? □Yes □No
- Do you have a high libido? □Yes □No
- How frequently do you have intercourse? _____ times per month
- Do you obtain an erection easily? □Yes □No
- Do you experience premature ejaculation? □Yes □No
- Is intercourse ever painful to you? □Yes □No
- Is intercourse ever painful for your partner? □Yes □No
- Do you use any form of lubrication for intercourse? □Yes □No
- Have you had children? □Yes □No
- Have you ever impregnated someone? □Yes □No. If yes; _____ (year)
- Have you ever been diagnosed with a varicocele? □Yes □No
- Have you ever had blood in your semen (during ejaculation)? If yes, when? □Yes □No
- Have you ever had mumps? □Yes □No
- Have you experienced a high fever in the last 6 months? □Yes □No
- Have you ever had a sexually transmitted disease? □Yes □No
- Did you have undescended testicles at birth? □Yes □No
- Have you ever been diagnosed with small or soft testis? □Yes □No
- Have you ever had trauma (injury) to your testicles? □Yes □No
- Have you ever had a white, green, or yellow discharge from the end of your penis? □Yes □No
- Do you frequently take hot baths, saunas, or steam baths? □Yes □No
- Do you have sweaty groin/genitals? · Yes · No
- Do you have genital/anal itching? · Yes · No
- Do you have genital/groin/buttocks pimples/sores/rashes? · Yes · No

UROLOGY:

- Have you ever had any urologic surgeries? · Yes · No
- Do you currently have any prostate conditions or chronic pelvic pain? · Yes · No
- Do you have a history of urinary tract infections? · Yes · No
- Have you ever had blood in your urine? · Yes · No
- How many times do you urinate: Day _____ Night _____
- Have you ever had a kidney stone? · Yes · No
- Do you have urinary incontinence (loss or leakage of urine)? · Yes · No
- Has your urinary flow changed? · Yes · No (If 'Yes' circle applicable: Decreased Force, Urgency, Interrupted Stream, Hard to Start, Dribbling, Control Problem, Straining to Urinate, Incomplete emptying, Other _____)
- Do you experience pain? · Yes · No (Circle applicable: before, during, after voiding)
- Do you experience urinary burning? · Yes · No
- What colour/shade of yellow is your urine? _____
- How many glasses of water do you drink in a day? _____

Yinstill REPRODUCTIVE WELLNESS

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SYMPTOMS & MEDICAL CONDITIONS

(underline applicable, please be thorough):

NEURO-PSYCHIATRIC:

Mental health problems
Neurological disorder
Depression
Nervous breakdown
Numbness of limbs
Multiple Sclerosis
Convulsions or epilepsy
Restlessness
Irritability
Headaches
Insomnia
Vivid dreams
Forgetful / poor memory
Difficult getting up in morning
Pensive / over-thinking
Foggy mind
Irritability / frustration / impatient
Emotional eating
Unfulfilled desires
Feeling of lump in throat
Aversion to heat
Aversion to cold
Dizziness
Blurred vision / poor night vision
Red / Dry / Itchy eyes
Visual problems / floaters
Grief / sadness
Live in fear

CARDIO-RESPIRATORY:

Stroke
Heart attack
High blood pressure
Arteriosclerosis
Fainting
Heart condition
Chest Pain
Palpitations
Heart murmur
Anemia
Ankle swelling
of breath
Asthma
Allergies
Tuberculosis
Chronic cough
Dry cough
Cough with Phlegm
Nasal discharge / drip
Sinus infection / congestion
Congenital defects
Spitting up blood
Night sweats
Respiratory issues
Pneumonia
Frequent sighing
Itchy / painful throat
Dry mouth / throat / nose
Weak immune system

MUSCULO-SKELETAL:

Back or neck surgery
Muscular control loss
Arthritis
Head injury
Tremors
Back injuries
Joint stiffness
Limitation of motion
Leg or knee problems
Varicose veins
Muscular tired / weak
Sensation or pain under rib cage
Brittle nails
Neck/should stiffness
Muscle twitches/spasms

GASTROINTESTINAL:

Stomach or bowel disorder
Diarrhea / loose stool
Alternate constipation / loose
Blood in stool
Ulcers
Frequent upset stomach
Hemorrhoids
Constipation
Heaviness in the head / body
Water retention
Bruise easily
Bad breath
Poor appetite
Large appetite
Crave sweets
Crave salty
Crave spicy
Poor digestion
Nausea / vomiting
Bloating
Gas
Abdominal pain
Intestinal pain / cramping
Heartburn
Yeast infection
Bitter taste in mouth
Tongue / mouth ulcers / cankers
Snoring

MISC:

Fatigue
Unusual bleeding
Feel cold easily
Cold hands / feet
Prefer Warm / Cold drinks
Sweat easily
Night sweats / hot flushing
Losing hair
Hearing problems
Tinnitus
Endocrine or glandular disorder
Liver or gallbladder problems
Typhoid fever
Gout
Cancer or tumor
Bleeding tendency
Diabetes
Polio
Hepatitis
Rheumatic fever
Skin rashes / hives

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Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of acupuncture?

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- Minor bleeding or bruising can occur from acupuncture;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days;
- Fainting can occur in certain patients, particularly at the first treatment;

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder;
- If you are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Privacy Policy

The information received and collected about our clients/patients from their visit to Yinstill is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Yinstill, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Yinstill (also, Yinstill will not give, share, sell, or transfer any personal information to a third party unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy format on Yinstill premises. On occasion, Yinstill may use client/patient information to conduct clinical studies to help us improve upon services provided.

Appointment Policy

We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us. Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A 24 hour notice for cancelled or rescheduled appointments is necessary in order to avoid a full 100% cancellation fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

Any questions regarding my appointments have been addressed. I have read this statement and fully understand it.

_____

Print name in full

_____ _____

Signature Date

Please print, complete, and bring with you to your initial appointment. Thank you.

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Patient Information Release Request Form

I, _____ (please print name) give full consent so that your Yinstill practitioner may consult freely with other physicians and healthcare professionals (of which whose care I am under) regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

(*to be filled out by your practitioner*)

The following is an authorization to provide Dr. Spence Pentland with the following information:

- All recent lab work results
- All medical records
- All semen tests
- Other: _____

Medical Services Plan (MSP) #:

I am nineteen years of age or older:

- Yes
- No

Client/Patient Signature: _____ Date: _____

Signature of parent or guardian (if applicable): _____

Thank-you. If you have any questions, please feel free to contact us.