

# MOSS

## ACUPUNCTURE

415 SPRUCE STREET, SAN FRANCISCO, CALIFORNIA 94118 | 415-244-4412 | WWW.MOSSACUPUNCTURE.COM

Date / /	First Name	Last Name			Middle Initial
Date of Birth / /	Age	Body Type	Height:	Weight:	Occupation:

Name of your doctor/ Fertility Specialist: RMFC / CCRM / FCC / Conceptions / CU

Other OBGYN doctor \_\_\_\_\_ Start Date: \_\_\_\_\_ Month/ Year

Western Diagnosis \_\_\_\_\_

### 1. Results for Sperm Analysis:

Date	Count	Morphology	Motility	Volume

### 2. Do you have a copy of your Semen Analysis?

Y / N

### 3. Other Procedures/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SCSA / ASA	Others

### 4. Do you take any of these Supplements and/or Vitamins?

# of Months on Vitamins	Male Vitamins	Mega Man	Fish Oil	L - Carnatine	L - Arganine	Antioxidants	EWA Complete List

Other:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 5. Couples ART Plans:

IUI	Clomid	IVF	PGD	TESA	Other

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### 6. Has the patient father children

Y / N                      If so, how many \_\_\_\_\_

### 7. Male Health

Infection	Chlamydia,	Erectile Dysfunction	Ejaculation Problems	Retrograde Ejaculation	Prostate
	Y / N	Y / N	Y / N	Y / N	Y / N

### 8. Male Health Continued

Antisperm Antibodies	Sperm Chromatid / DNA Integrity	High Cholesterol	Diabetes (fasting, glucose)	Others
Y / N	Y / N	Y / N	Y / N	

### 9. Is you Spouse currently being treated by us?

Y / N

Spouse's Name \_\_\_\_\_

Western Diagnosis of Spouse \_\_\_\_\_