andress acupuncture

845.674.3778

166 Albany Ave. Kingston, NY 12401 • 120-126 North Main St. New City, NY 10956 • www.andressacupuncture.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 - Carrnatine	L - Arganine	Antioxidants	EWA Complete List

Other: ________________________________

____

____

5. Couples ART Plans:

IUI	Clomid	IVF	PGD	TESA	Other

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 ____