

# Male Fertility Medical History

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Email \_\_\_\_\_

Home Phone(\_\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_\_) \_\_\_\_\_ Cell(\_\_\_\_\_) \_\_\_\_\_  
Which phone is best to leave messages on? \_\_\_\_\_

Name of spouse or significant other? \_\_\_\_\_  
Can we discuss your health with him/her? Circle Yes/No

Main Concern(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For how long? \_\_\_\_\_

What has been diagnosed by (M.D., ect) \_\_\_\_\_

What have you tried for your main concern? \_\_\_\_\_

Have you ever tried acupuncture or herbs? If so why did you discontinue? \_\_\_\_\_  
\_\_\_\_\_

Dietary Restrictions \_\_\_\_\_

Food Sensitivities/Allergies \_\_\_\_\_

Food Cravings \_\_\_\_\_

Drug/Herb/Environmental Allergies \_\_\_\_\_

Social Drugs, Mark past or present (coffee, alcohol, sugar, tobacco, marijuana,ect.)

Are you taking any medications? **Please list ALL medications, herbs, vitamins and minerals you take. Why you take them and the dose**, even if it is occasionally, including anti-histamines and anti-inflammatory drugs. You can bring them to your first visit as well.

Please list locations of any scars that are numb,sore,painful or inflamed:\_\_\_\_\_

### Reproductive Health History

Have you ever impregnated a woman before?\_\_\_\_\_

If so, when?\_\_\_\_\_

Have you fathered any children? Yes/No If so how many and what are their ages?\_\_\_\_\_

Were there any genetic complications?\_\_\_\_\_

Have you experienced any of the following? Mark "C" for current and "P" for past:

- \_\_\_\_\_ low libido
- \_\_\_\_\_ erectile dysfunction
- \_\_\_\_\_ premature ejaculation
- \_\_\_\_\_ retrograde ejaculation
- \_\_\_\_\_ numbness in one or both feet
- \_\_\_\_\_ back pain/numbness
- \_\_\_\_\_ difficulty attaining an erection
- \_\_\_\_\_ difficulty maintaining an erection
- \_\_\_\_\_ injuries or surgeries to the penis, testicles, abdomen or low back

Describe injury or surgery:

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Are you fatigued? If so, what time of day? \_\_\_\_\_

Have you had a semen analysis? \_\_\_\_\_ If so, please email a copy to Dr. Rozenn at [office@AcupunctureSantaCruz.net](mailto:office@AcupunctureSantaCruz.net) or bring it with you at your first appointment.

Do you drink from plastic water bottles, or eat food cooked in plastic containers? \_\_\_\_\_

Is soy part of your diet? \_\_\_\_\_

Are you or have you ever been regularly exposed to chemicals? High-risk jobs or endeavors include: mechanics, carpentry, painting, home improvements, ect.

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### Emergency Contact Information

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship \_\_\_\_\_

Is there anything else I should know about your health? \_\_\_\_\_

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## **Chronological Life History**

**\*\*\*Very Important! Please spend some time with this section and be as detailed as possible.**

(examples: difficult birth such as premature delivery, C-Section, cord around your neck, etc., minor or major surgeries, broken bones, landmark emotional events, loss of consciousness...all the way from your birth to the present day)

**First list age, then event**

# Family History

Use a **C** for a **Current Problem** or a problem still present at the death of the individual indicated  
 Use an **H** if it is a **historical condition** that is not present now or was not present when person deceased  
 I understand that you may not be aware of these condition in many cases; leave these blank

Condition or Disease	Biological	Biological	Spouse or	Brother(s)	Sister(s)	Children
	Father	Mother	Partner			
AGE of Individual						
Asthma						
Hay fever/ Seasonal Allergy						
Food Allergy / Sensitivity						
Eczema						
Psoriasis						
Other Skin Disorder						
Diabetes I - Juvenile						
Diabetes II – Adult						
Hyperthyroid or Graves Disease						
Hypothyroid or Hashimotos						
Osteoporosis or Bone Problems						
Rheumatoid Arthritis						
Other Arthritis or joint pain						
Lupus or other Immune Disorder						
Liver Disease						
Hepatitis						
Gallbladder Removed						
Gallstones						
Kidney Stones						
Kidney disease						
Heart Disease or problem						
Stroke						
High Blood Pressure						
Cholesterol problems						
Cancer – Include Type						
Digestive Disorder						
Weight Problem						
Anorexia, Bulemia, Eating Disorder						
Crohns, Ulcerative Colitis, Colitis						
Irritable Bowel						
Chronic Constipation						
Alcohol Abuse or Excess						
Insomnia						
Anxiety						
Depression						
Other: _____						
_____						
_____						
_____						
_____						



## **HIPAA Notice of Privacy and Confidentiality & Patient's Rights**

**Patients' rights under HIPAA are described in the "Notice of Privacy Practices" The Notice will be made available to patients. These rights include:**

1. Right to receive the "Notice of Privacy Practices", which informs patients of their rights and how to exercise them. By law this notice is to be made available to patients, and a good faith effort to obtain the patient's acknowledgement of receipt is required.
2. Right of Access. Patients may request to inspect their medical record and may request copies. There may be a fee to produce the copiers. The process to follow and how to request copies is explained in the "Notice of Privacy Practices."
3. Right to Request and Amendment or Addendum. The Notice describes how to file a request for an amendment or addendum.
4. Right to an Accounting of Disclosures. Patients have the right to receive an accounting of disclosures of their Patient Health Information (PHI). The Notice describes how to request an accounting.
5. Right to Request Restrictions. Patients have the right to request restrictions on how they will be communicated with or how their PHI is released. Generally, every effort to try to accommodate reasonable requests for restrictions, e.g., where release of information could be harmful to the patient.
6. Right to Complain. Patients have the right to complain if they think that privacy rights have been violated. The "Notice of Privacy Practices" describes where to file a complaint.

### **Exceptions to the Rules**

**Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the "Notice of Privacy Practices". Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena**

**Notice of HIPAA Privacy Practice**

**The attached Notice describes how health information about you may be used, and your rights, regarding the use of that information. Please review it carefully.**

**You have the right to:**

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary)
- Ask to correct information that you believe is wrong in your health record
- Ask that your health information not be used for certain purposes, for example, research
- Ask that copies of your health record be sent to whomever you wish (charges may be necessary)
- Be informed about who has read your record (for reasons other than treatment, payment, and program improvement purposes).
- Specify where and how you should be contacted
- Receive a paper copy of the full Notice of Privacy Practices

**Who is authorized to see confidential Patient Health Information (PHI)?**

The “Notice of Privacy Practices” describes the ways in which your PHI may be used without obtaining the patient’s specific authorization. Certain uses such as for Treatment, Payment and health care Operations are permitted.

1. Treatment of the patient, such as consultation between treating providers
2. Payment of health care bills (insurance claim submission, authorizations and payment posting)
3. Health care operations and business operations, including research (when approved by the IRB and with a patient’s written permission); health care communications between a patient and their health care practitioner.

**Written Authorizations**

To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refer to the “Notice of Privacy Practices” for a list of covered exceptions to the authorization requirement related to public policy, certain health disease reporting requirements and law enforcement activities. If you do not understand or know what you can do with PHI, please read the “Notice of Privacy Practices”.

**Exceptions to the Rules**

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the “Notice of Privacy Practices”. Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial request or subpoena.

If you have concerns about how your health information might be (or has been) shared, please speak with your practitioner or the privacy coordinator. If you believe your privacy rights have NOT been maintained you may file a complaint with the Secretary, the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. You will not be penalized in any way for filing a complaint.

- I acknowledge receipt of the “Notice of Privacy Practices” and “Patient’s Rights”. I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the full Notice.
- I understand and acknowledge that I may receive appointment reminder calls, newsletters, and cards, and I agree to receive these.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Printed Name \_\_\_\_\_ Relation (if other than the patient) \_\_\_\_\_

Patient declined to sign receipt (signature of practitioner) \_\_\_\_\_

Patient unable to sign (witness signature) \_\_\_\_\_ Reason unable \_\_\_\_\_

# **INFORMED CONSENT**

I request and consent to the performance of procedures which are within the scope of a California license to practice acupuncture. This includes, but is not limited to, acupuncture treatments on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists or students who now or in the future treat me while working under, associated with, or serving as backup for Dr. Maureen Rozenn. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion(moxa) and heat therapy, cupping, electro-acupuncture, medical massage modalities such as Tui-Na or Mayan Abdominal Therapy, dietary supplements, herbal therapy, and nutritional counseling. Moxibustion and heat therapy including heat lamps, tiger warmers, cone, pole and Japanese moxibustion may cause discomfort and in rare cases may cause burns. I will alert the acupuncturist, or person supervising the progress of my moxa treatment, immediately if any type of heat therapy is uncomfortable. The acupuncturist may choose to perform a form of moxibustion which consists of placing small rice sized pieces of moxa on an ointment barrier and lighting them to stimulate certain acupuncture points. I will decline the procedure if I do not wish to receive this or any other treatment.

I understand that acupuncture treatments are generally safe, but may have some side effects including bruising, numbness or tingling near the needling sites that may last a couple of minutes to a few days, dizziness or fainting, and nausea. I will notify the acupuncturist immediately if I feel uncomfortable at any time during or after treatment. There have been instances reported of spontaneous miscarriage and pneumothorax, although these side effects are very rare. Infection is another possible risk, although the acupuncturist only uses sterile, disposable acupuncture needles.

Herbs that have been used in treatment, or are recommended, are traditionally considered safe in the practice of Oriental Medicine, but may be toxic in large doses. Some of the possible side effects of taking herbs are: nausea, gas, hives, rashes, diarrhea, vomiting and tingling of the tongue. If I experience anything unusual during herbal treatment I will notify the acupuncturist immediately. I understand that some herbs and other therapies may be inappropriate during pregnancy. I will notify the acupuncturist if I think I may be pregnant.

Oriental medicine can be used to treat pregnant women for all sorts of disorders ranging from low back pain to the common cold. I understand that while labor induction and pain management during labor are within the acupuncturist's scope of practice, she does not specifically induce or treat women in labor. Treatment (pre-birth treatments) can be administered to prepare women for labor. Also, there are specific points and techniques traditionally used to help the mother promote correct fetal position. When treatment appropriate for my Chinese medical diagnosis is given during the last few weeks of pregnancy, or when past the due date, labor may start or a breech baby may turn. I understand this is a possibility and that if I am not willing to take this risk I will refuse treatment.

Cosmetic acupuncture results are not guaranteed. Facial skin is delicate and full of superficial blood vessels. Bruising can occur and scarring is a theoretical possibility.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the acupuncturist to be able to anticipate and explain all of the risks and complications. I wish to rely on the acupuncturist to exercise judgment and perform, during the course of my treatments, based upon the facts then known, the therapy that is in my best interest.

I understand that results are not guaranteed. I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, 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 for any future conditions for which I may seek treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

(Or Patient Representative)

Acupuncturist Signature \_\_\_\_\_ Date \_\_\_\_\_





**Maureen Rozenn, LAC, DAOM, FABORM**  
Doctor of Acupuncture and Oriental Medicine  
845 Cedar Street, Santa Cruz, CA 95060  
Phone: 831.426.1093 Fax: 831.426.6523

## **Directions**

### **From Highway 17 or 1 North**

1. From highway 17 or 1 North, exit into Santa Cruz towards 1 North to Half Moon Bay.
2. Go straight through the first light at River St. and Highway 9.
3. Go straight through the second light at the cross between Mission, Highway 1 and Chestnut.
4. Going straight through this light will put you on Chestnut Street.
5. Continue down Chestnut and make a left on Walnut.
6. The parking lot for Plaza de la Cruz is on Walnut Street, just before it intersects with Cedar Street.
7. The Clinic is on the Cedar Street side of Plaza de la Cruz.

**Be sure to park in one of several spaces labeled, "Customers." If the lot is full, there is metered street parking and a paid lot directly across Cedar Street from the clinic.**

### **From North of Santa Cruz**

1. If coming from North of Santa Cruz, follow 1 South into Santa Cruz.
8. It will become Mission Street.
9. Go right on Chestnut.
10. Go left on Walnut.
11. The parking lot for Plaza de la Cruz is on Walnut Street, just before it intersects with Cedar Street.
12. The Clinic is on the Cedar Street side of Plaza de la Cruz.

**Be sure to park in one of several spaces labeled, "Customers." If the lot is full, there is metered street parking and a paid lot directly across Cedar Street from the clinic.**

# Terms of Care - Our Cancellation Policy

## Please Read Carefully!

**By signing below, I agree that I have read in full and will adhere to the following office policies without exemption:**

- Patients are solely responsible for tracking and keeping any appointments scheduled online or via the front desk.
- If you are 15 or more minutes late, you have missed your appointment and are responsible for full payment of your appointment cost.
- If you're sick, please keep your appointment (we can help!). If you're too ill to drive, contact us ASAP.
- Cancellations must be 48+ hours in advance to avoid a cancellation fee.
- The fee for cancellations under 48 hours is half the appointment price.
- The fee for cancellations under 24 hours is the full appointment price.
- The fee for no-shows and late arrivals by 15 minutes or more is the full appointment price.
- Three missed appointments in a row results in a discharge from care.
- Email reminders are in no way guaranteed, and they do not affect the cancellation policy in any way.
- If I do not read my appointment reminder correctly, or if my device causes a skewed representation of my appointment time via email reminder, I know that I am nonetheless responsible for my appointment time as it is scheduled in Dr. Rozenn's appointment software. I know that I am subject to cancellation fees if I miss my appointment for this reason. I know that email reminders are a courtesy only and relying on email reminders is an inappropriate way to keep track of my appointments.

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Printed Name

Date

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Signature



### **Hello, and welcome to my practice!**

Congratulations on taking the first step to better health! As a Doctor of Acupuncture and Oriental medicine, I practice Integrative medicine. My tools include acupuncture, herbal therapy, diet and lifestyle counseling, and nutritional supplements. I utilize Western lab reports when appropriate, as well as traditional Oriental diagnostics, to guide your treatment and help you reach your personal health goals.

**During our first meeting we will go over your health history. So, along with the enclosed paperwork, bring any herbs/supplements/drugs you are currently taking to your first appointment. Be sure to bring any pertinent lab work and imaging reports.**

In accordance with ancient teaching methods of Oriental medicine's tradition, Endless Possibilities Acupuncture, Inc. is an education-focused practice. Chinese medicine students, known as interns, assist me daily with various clinic duties. This includes observing patient visits, taking chart notes, and preparing patient materials based on my instructions during your appointment. If for any reason you do not wish to have a student observing your visit, please let me know, as your comfort is most important.

Please allow 2 hours for your initial visit. The cost of the first visit is \$220.00. These visits last approximately 2 hours. Women's Fertility Visits are \$255.00 and last approximately 2.5 hours. Follow up visits, which include an office visit and acupuncture, are \$140.00 and last between 60-75 minutes. These estimates include time for parking, checking out, etc. While I do not bill insurance directly, you may request an insurance receipt when checking out at the end of your visit. If you have any questions about this, please ask my assistant at the front desk. If you need to cancel or reschedule, please notify us at least 48 hours in advance by phone or email to avoid a late-cancellation fee.

My schedule tends to book out in advance, with most appointment openings falling about six weeks from the current date. If you need your planner to book ahead, please bring it. If you can't get in on the appointment date you need, do not worry, we have a very effective cancellation list! Ultimately, Chinese medicine is most profound when treated as a partnership between doctor and patient. If we work together, you will learn more than you ever dreamed about your body, including how to maintain the balance we achieve in the clinic... in your own life, on your terms.

For more information about me and my practice, visit my website [www.AcupunctureSantaCruz.net](http://www.AcupunctureSantaCruz.net). You can contact my office at [office@AcupunctureSantaCruz.net](mailto:office@AcupunctureSantaCruz.net). I look forward to your visit!

Sincerely,  
Dr. Maureen Rozenn, LAC, DAOM, FABORM

