2330 NW Flanders Suite 101, Portland OR 97210 (Westside)
T (503) 701-8766 F (503) 241-5484
3115 NE Sandy Blvd Suite 231, Portland, OR 97232 (Eastside)
T (503) 701-8766 F (971) 255-0727
KwanYinHealingArts.com

NEW PATIENT NATUROPATHY/ACUPUNCTURE INTAKE

Legal last name _____ Legal first name _____ MI_____

Preferred Name_____

Address _____ City _____ State _____ Zip_____

Phone #_____ Work# _____ DOB _____ Age _____

Email _____ Legal Sex _____ Gender Identity _____

Pronouns _____ Relationship status _____

Employer/Occupation _____ Hours/week _____

Do you live with anyone? If so, whom? _____

Emergency contact/relationship _____ Phone# _____

Primary care physician _____ Phone# _____

How did you hear about our clinic? _____

When and where did you last receive medical/health care? _____

For what reason? _____

Insurance information

Please note that it is your responsibility to know your coverage and benefits.

Though we do not accept Medicaid, we need to know if you are covered by any Medicaid or OHP Plan Y ☐ N ☐

Insurance type: None ☐ Medical ☐ Auto Injury ☐ PIP/Personal injury ☐ Work injury/Work comp ☐

Insured's name _____ DOB _____ Patient's relationship to insured _____

Name of insurance company _____ Claims address _____

Phone# _____ ID# _____ Group# _____

Secondary (medical) insurance

Insured's name _____ DOB _____ Patient's relationship to insured _____

Name of insurance company _____ Claims address _____

Phone# _____ ID# _____ Group# _____

If Auto/PIP/Work comp injury

Date of injury _____ Claim# _____ Policy# _____

Describe how injury happened _____

Adjuster name _____ Phone# _____

Name of attorney _____ Phone# _____

Were you working at the time of the accident (or driving during work duty)? Y☐ N☐

Dates lost from work as a result of this injury _____

If auto injury, were you the: Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist ☐

Was the vehicle: Rear ended ☐ Hit from R side ☐ Hit from L side ☐ Hit head on ☐

KWAN YIN OFFICE POLICIES

Kwan-Yin Healing Arts Center, Inc. (KYHAC) welcomes you as a new patient. If you have any questions regarding our office policies, please ask any of our front desk staff for clarification prior to initialing.

Please initial each of the following:

_____**Cancellation Policy:** We require 48-hour notice for cancellations and rescheduling of appointments. If you fail to cancel 48 hours prior to the appointment, a late fee will be assessed to you (fees vary by provider), due prior to the start of your next visit. You will be personally responsible for the fee; it cannot be billed to your insurance company.

_____**Supplements:** Any and all supplements, supplies, herbs, etc. prescribed by my provider and/or purchased by me at KYHAC are my full financial responsibility with payment to be made at the time of service/purchase. KYHAC cannot bill for these items.

_____**Returned Check Policy:** KYHAC has a $35 fee for all returned checks.

_____**Patient Insurance:** Insurance information given to KYHAC by your insurance company is not a guarantee of payment. This includes information provided about covered treatments, copays, coinsurance, deductibles, and pre-authorizations. Please remember your insurance policy is an agreement between you and the insurance company and it is ultimately your responsibility to pay for any balance not paid or covered by insurance. Charges that are not covered by the given insurance company will be billed to you.

_____**Non-Covered Services:** Occasionally, your health insurance carrier, including **Medicare**, may not cover some or any of our services. If for any reason one or more of the services we provide is not covered, you will be billed for those services directly, and payment for those services will be your responsibility.

_____ **Animal Policy:** Only trained service dogs are allowed to accompany patients in the clinic.

_____**Cell Phones:** For the comfort of our patients, we prohibit cell phone conversations in the clinic. Please take all calls to the hallway and turn off all cell phones before entering the treatment rooms.

_____**Medicare/Medicaid:** Any chiropractors at Kwan Yin Healing Arts Center ***cannot*** **treat or bill services** for Medicare members, per Medicare regulations.

Please verify that you understand all our office policies by signing and dating below.

_____	_____	_____
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

NON-COVERED SERVICES WAIVER/ACKNOWLEDGEMENT

SERVICES/SUPPLEMENTS/SUPPLIES

I understand and agree to the following:

- Any and all supplements, supplies, herbs, formulas, etc. prescribed by my provider and/or purchased by me at Kwan Yin Healing Arts Center are my full financial responsibility with payment to be made at the time of service/purchase. No open products can be returned to the clinic for refund under any circumstances.
- Kwan Yin Healing Arts Center does not bill insurance carriers, health saving plans or any other like entities for any supplements, herbs, formulas, or supplies. It is my full responsibility to submit the required information to these entities for reimbursement.
- Treatment/services such as moxa, cupping, hydrotherapy, energy work, injections, IV therapy, etc. are generally not covered by insurance carriers and are my full financial responsibility *(except where specifically determined by my insurance carrier as included in the primary treatment/service being rendered and clearly stated in the insurance contract with the treating provider)*.
- It is my full financial responsibility to pay for any charges previously covered/paid by my insurance carrier to the provider and/or Kwan Yin Healing Arts Center which: **1)** is later deemed by my insurance carrier to not be "medically necessary", and **2)** has resulted in a partial or full refund request by my insurance carrier from the provider or Kwan Yin Healing Arts Center.

MEDICARE / MEDICAID

I understand and agree to the following:

- It is my full responsibility to inform staff and providers of Kwan Yin Healing Arts Center that I am a Medicare and/or Medicaid member ***prior to*** scheduling an appointment or receiving services.
- Medicare currently does not recognize, contract with, or cover alternative care (CAM) providers; any services provided to me or charges incurred by me as a Medicare member are my full financial responsibility.
- Any chiropractors at Kwan Yin Healing Arts Center ***cannot*** **treat or bill services** for Medicare members, per Medicare regulations.
- Kwan Yin Healing Arts Center is not contracted with any Medicaid plans; any services provided to me or charges incurred by me as a Medicaid member are my full financial responsibility.
- If I am a both a Medicare and Medicaid member and choose to receive services at Kwan Yin Healing Arts Center, I am fully aware that payments for any services, supplements, supplies, etc. are my full financial responsibility and **these charges *cannot* be billed** by either me or Kwan Yin Healing Arts Center to Medicare or Medicaid.

I have fully read and understand the above agreements and information.

_____	_____	_____
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

HIPAA NOTICE of PRIVACY PRACTICES & CONSENT/WRITTEN ACKNOWLEDGEMENT

I hereby consent to the use and disclosure of my protected health information by Kwan Yin Healing Arts Center for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

- I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Kwan Yin Healing Arts Center prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.
- I have the right to request restrictions to the usage and disclosure of my protected health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Kwan Yin Healing Arts Center may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Kwan Yin Healing Arts Center at the following address

3115 NE Sandy Boulevard, Suite 231
Portland, OR 97232
2330 NW Flanders St, Suite 101
Portland, OR 97210

- I understand that if I have any questions or complaints, I may submit them in writing to the address above or contact Kwan Yin Healing Arts Center by phone at: **503-701-8766**.
- I am aware that Kwan Yin Healing Arts Center reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Kwan Yin Healing Arts Center will make available a revised Notice of Privacy Practice for my review.

_____	_____	_____
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

_____ _____ _____

THIS SECTION to be COMPLETED by KWAN YIN HEALING ARTS CENTER if UNABLE to OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to, because:

- ☐ Patient declined to sign this Written Acknowledgement
- ☐ Other (please specify):

_____	_____	_____
Printed Name & Title of Employee	Signature of Employee	Date

EMAIL AND TEXT CONSENT FORM

Before sending e-mail/text communications to Kwan Yin Healing Arts Center Providers ("Kwan Yin"), please read and agree to the following information regarding the risks and conditions of e-mail/text use:

RISKS ASSOCIATED WITH USING E-MAIL/TEXT

Kwan Yin offers patients the ability to communicate by e-mail/text. However, transmitting patient information by e-mail/text has a number of risks that should be considered. These include, and are not limited to, the unintentional disclosure of your personal health information to third parties and other unintended persons. Electronic communications sent through public servers are, by their nature, unsecure and unprotected. Please be aware of this, if you choose to communicate with your providers in this fashion and understand that your decision to utilize this method of communication constitutes a waiver of privacy rights you may have regarding this information.

CONDITIONS FOR THE USE OF E-MAIL/TEXT

Kwan Yin will use reasonable means to protect the security and confidentiality of e-mail/text information sent and received. However, Kwan Yin cannot guarantee the security and confidentiality of e-mail/text communication and will not be liable for improper disclosure of confidential information. Thus, individuals must consent to the use of e-mail/text communication.

Please understand, under no circumstance should text or email communications be used in case of emergency or time-sensitive matters. Please call 911 for emergencies and go to the nearest urgent care or immediate care center for urgent matters.

Electronic transmissions can be misdirected and/or intercepted. Please exercise great care in deciding what information you should share with your providers in this fashion. For instance, individuals should avoid using e-mail/text communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

ACKNOWLEDGEMENT & AGREEMENT

I understand and acknowledge that I have read and fully understood this consent form. I request and consent to Kwan Yin using e-mail/text to communicate with me at the e-mail address(es)/telephone number(s) that I provide, and I understand that such communications may contain my protected health information, including health history, diagnosis and treatment information and demographic information. I understand the risks associated with e-mail/text communication between Kwan Yin and me, and consent to the conditions outlined above. I understand and acknowledge that I have the right to withdraw my consent in writing at any time and that this authorization shall remain in effect until I withdraw my consent. Furthermore, I understand that Kwan Yin will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

_____	_____	_____
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

ACUPUNCTURE INFORMED CONSENT TO TREAT

Please read and sign below if the practitioner you are seeing has an acupuncture license.

I understand that acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. I understand that my care providers will appropriately assume I am under the care of a primary care physician or medical specialist; that if I am pregnant or nursing, I am being managed by an appropriate healthcare professional; and that if I have cancer, I am under the care of an oncologist.

I have been informed that there are risks to acupuncture and other care techniques practiced at the Clinic, including, but not limited to: infection; bruising; numbness or tingling near the needling sites that may last a few days; nerve damage; organ puncture; and dizziness or fainting. Burns and/or scarring are potential risks of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping.

I understand that the herbs used or recommended in my course of care may need to be prepared and the teas consumed according to the instructions provided. Some herbs may have an unpleasant odor or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects that may occur. I understand that herbs and nutritional that may be recommended may be toxic in large doses. I also understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient 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 confirm that 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 condition(s) for which I seek treatment.

_____	_____	_____
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

Patient Health Questionnaire

Holistic Health and preventative care are only possible when the provider has complete understanding of the patient physically, mentally, and emotionally. Please complete this form as thoroughly as possible. Thank you.

Health Concerns

Please list your concerns, in order of importance, including what brings you in today.

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

Prior treatment and response? _____

What do you think caused your symptoms? _____

What positive attributes can you describe about your health? List as many as you can.

_____

Allergies and reactions: Please list all known reactions to food, drugs, environment, or other allergies.

_____

_____

Please list all prescriptions medications, over the counter medications, vitamins, supplements, and herbs you have taken in the past 2 months, with dosages.

_____

_____

Hospitalizations, surgeries, and major injuries: please list type and when they occurred.

_____

_____

Any other significant traumas? _____

Occupational stressors (chemical, physical, psychological)? _____

Imaging and special studies (Xray, MRI, CT, PET, EKG, EEG, U/S): Please list type and date performed.

_____

_____

Birth History Birth history is not known ☐

Age of parents at conception: Mother _____ Father _____ Birth order _____ of _____

Brief birth history (trauma, c-section, parental drug use, forceps, breech, etc.) _____

Health in childhood _____

Major or chronic childhood illness (earaches, asthma, measles, etc.) _____

Vaccination history unknown ☐ All normal childhood vaccines ☐ Did not receive childhood vaccines ☐

Vaccines as an adult ☐ Any reactions to vaccines? _____

Family History Family medical history is not known ☐ Are you of Ashkenazi Jewish descent? Y☐ N☐

Please list age or (age at death/cause): Mother _____ Father _____ Siblings _____

Family Cancer history: Are you concerned about your personal or family history of cancer Y☐ N☐

Relationship _____ Type/location _____ Age at diagnosis _____

Relationship _____ Type/location _____ Age at diagnosis _____

Family History continued…

Any close relatives with:

☐ Allergies/Hay Fever	☐ Bleeding Disorder	☐ High Blood Pressure	☐ Sickle Cell (SCD, SCT)
☐ Alzheimer's/Dementia	☐ Depression/Anxiety	☐ Genetic Disease	☐ Stroke
☐ Arthritis	☐ Diabetes	☐ Kidney Disease	☐ Thyroid Disorder
☐ Asthma	☐ Eczema/Psoriasis	☐ Mental Illness	☐ Other:_____
☐ Autoimmune	☐ Food Intolerances	☐Osteoporosis/Osteopenia	
	☐ Heart Disease	☐ Seizures	

Diet and Lifestyle

Are you currently pregnant? Y☐ N☐ Due date _____ Do you enjoy your work/daily activities? Y☐ N☐

Do you sleep well? Y☐ N☐ Do you wake rested? Y☐ N☐ Average number of hours of sleep? _____

Do you exercise? Y☐ N☐ How often/what kind? _____

After exercise do you feel: More fatigued ☐ More energized ☐ Neither ☐

Have you experienced an eating disorder or disordered eating? Y☐ N☐ Not sure☐ When _____

Tobacco use? Y☐ N☐ Past☐ Quantity/type _____

Alcohol use? Y☐ N☐ Past☐ Quantity/type _____

Treated for addiction/alcoholism? Y☐ N☐ When? _____

Cannabis? Y☐ N☐ Caffeine? Y☐ N☐ Soda? Y☐ N☐ Sugar? Y☐ N☐

How much vacation do you take? _____ How much screen time a day? _____

How much time do you spend outdoors? _____

What are the current stressors in your life? _____

What do you do for self-care? _____

Height _____ Current Weight _____ Lowest weight/When _____ Max Weight/When _____

How many meals do you eat a day? _____ Any food avoids? _____

Morning meal _____

Afternoon meal _____

Evening meal _____

Current Musculoskeletal Pain

Primary area of pain? _____

Other areas of pain? _____

When and how did pain start? _____

Intensity of pain, scale of 1-10? Currently _____ Worst this week _____ Best this week _____

Qualities of pain? Constant ☐ Intermittent ☐ Sharp ☐ Radiating ☐ Numbness/tingling ☐

Since onset, is the pain? Improving ☐ Getting worse ☐ Unchanged ☐

Have you ever had this pain before? Y☐ N☐ When? _____

What activities are limited by pain? _____

Body Systems Please check any symptoms that you currently experience (C) or have had in the past (P)

Head and Neck/EENT

C☐ P☐ Headaches
C☐ P☐ Migraines
C☐ P☐ Changes in vision
C☐ P☐ Spots/blurry/double vision
C☐ P☐ Cataracts
C☐ P☐ Impaired vision
C☐ P☐ Glaucoma
C☐ P☐ Eye pain/strain
C☐ P☐ Tears or dry eyes
C☐ P☐ Ear ringing/tinnitus
C☐ P☐ Earaches
C☐ P☐ Impaired hearing
C☐ P☐ Nose bleeds
C☐ P☐ Stuffy nose
C☐ P☐ Dry mouth/throat
C☐ P☐ Hay fever
C☐ P☐ Sinus problems
C☐ P☐ Loss of smell
C☐ P☐ Neck lump/goiter
C☐ P☐ Swollen glands
C☐ P☐ Neck pain/stiffness
C☐ P☐ Jaw clicks/pain/TMJ
C☐ P☐ Dental work
C☐ P☐ Frequent sore throat
C☐ P☐ Gum problems
C☐ P☐ Copious saliva
C☐ P☐ Teeth grinding
C☐ P☐ Tongue/lip sores

Cardiovascular

C☐ P☐ Cold hands/feet
C☐ P☐ High blood pressure
C☐ P☐ Low blood pressure
C☐ P☐ Anemia
C☐ P☐ Swelling in hands/feet
C☐ P☐ Palpitations/fluttering
C☐ P☐ Fainting
C☐ P☐ Easy bleeding/bruising
C☐ P☐ Murmurs
C☐ P☐ Irregular heartbeat
C☐ P☐ Varicose veins
C☐ P☐ Blood clots
C☐ P☐ Deep leg pain
C☐ P☐ Phlebitis
C☐ P☐ Heart disease
C☐ P☐ Chest pain
C☐ P☐ Angina
C☐ P☐ Atherosclerosis
C☐ P☐ Congestive heart failure

Gastrointestinal

C☐ P☐ Strong thirst
C☐ P☐ Poor appetite
C☐ P☐ Heavy appetite
C☐ P☐ Changes in appetite
C☐ P☐ Cravings
C☐ P☐ Bad breath
C☐ P☐ Gas or burping
C☐ P☐ Heartburn
C☐ P☐ Nausea/vomiting
C☐ P☐ Foul smelling stools
C☐ P☐ Diarrhea
C☐ P☐ Hemorrhoids
C☐ P☐ Constipation
C☐ P☐ Laxative use
C☐ P☐ Ulcer
C☐ P☐ Pain or cramps
C☐ P☐ Rectal pain
C☐ P☐ Trouble swallowing
C☐ P☐ Blood in stool
C☐ P☐ Black stools
C☐ P☐ Gall Bladder disease
C☐ P☐ Liver disease
C☐ P☐ Jaundice
C☐ P☐ Appendicitis

Bowel movements: Frequency _____ Color _____ Texture/shape _____

Respiratory

C☐ P☐ Cough
C☐ P☐ Tight chest
C☐ P☐ Shortness of breath
C☐ P☐ Difficult/painful breathing
C☐ P☐ Allergies/hay fever
C☐ P☐ Asthma/wheezing
C☐ P☐ Bronchitis
C☐ P☐ Pneumonia
C☐ P☐ Coughing blood
C☐ P☐ Emphysema
C☐ P☐ COPD
C☐ P☐ Tuberculosis

Urinary

C☐ P☐ Frequent urination
C☐ P☐ Nighttime urination
C☐ P☐ Urinary urgency
C☐ P☐ Leakage/incontinence
C☐ P☐ Painful urination
C☐ P☐ Frequent infections
C☐ P☐ Blood in urine
C☐ P☐ Kidney stones

Immune

C☐ P☐ Frequent colds
C☐ P☐ Slow wound healing
C☐ P☐ Chronic fatigue
C☐ P☐ Chronic infections
C☐ P☐ Chronic swollen glands
C☐ P☐ Chronic/contagious disease
C☐ P☐ HIV/AIDS

COVID diagnosis (dates, effects) _____

Neurologic

C☐ P☐ Poor balance
C☐ P☐ Poor coordination
C☐ P☐ Poor memory
C☐ P☐ Brain fog
C☐ P☐ Numbness or Tingling
C☐ P☐ Vertigo or dizziness
C☐ P☐ Neurodivergent
C☐ P☐ Seizures
C☐ P☐ Tremors
C☐ P☐ Paralysis
C☐ P☐ Head injury

Concussion (date/s, effects) _____

Endocrine

C☐ P☐ Insomnia/poor sleep
C☐ P☐ Heavy sleep
C☐ P☐ Fevers
C☐ P☐ Chills
C☐ P☐ Changes in body temp
C☐ P☐ Hyperthyroid
C☐ P☐ Hypothyroid
C☐ P☐ Hypoglycemia
C☐ P☐ Diabetes
C☐ P☐ Fatigue
C☐ P☐ Unexpected weight gain/loss
C☐ P☐ Excessive/changes to thirst
C☐ P☐ Heat/cold intolerance

Sudden energy drop at _____ Peculiar tastes/smells _____

Musculoskeletal

C☐ P☐ Muscle spasms/cramp
C☐ P☐ Muscle weakness
C☐ P☐ Sciatica
C☐ P☐ Joint or bone pain
C☐ P☐ Foot trouble
C☐ P☐ Neck pain
C☐ P☐ Low back pain
C☐ P☐ Jaw pain
C☐ P☐ Arthritis
C☐ P☐ Hernia
C☐ P☐ Fibromyalgia
C☐ P☐ Orthotics

Old injuries/dates _____

Skin

C☐ P☐ Rashes/hives
C☐ P☐ Itching
C☐ P☐ Acne/pimples/boils
C☐ P☐ Rosacea
C☐ P☐ Eczema
C☐ P☐ Cold sores/ulcers
C☐ P☐ Changes in hair/skin
C☐ P☐ Unusual hair loss
C☐ P☐ Unusual sweats
C☐ P☐ Lack of sweat
C☐ P☐ Night sweats

Emotional/psychological

C☐ P☐ Depression
C☐ P☐ Seasonal depression
C☐ P☐ Anxiety
C☐ P☐ Short temper
C☐ P☐ Easily stressed
C☐ P☐ History of abuse
C☐ P☐ Thoughts of suicide
C☐ P☐ Mental health diagnosis
C☐ P☐ Treatment for emotional/psychological problems

Sexual health

Are you sexually active? _____ Sexual orientation? _____ Birth control? _____

Difficulties/changes in desire or function? _____ Fertility issues? _____

Do you have a menstrual history? Y☐ N☐ Age at first menses _____ Most recent menses _____

Length of cycle, one to the next _____ Days of flow _____ Date of last PAP _____

Menopause? Y☐ N☐ Hot flashes/night sweats Y☐ N☐ Other menopausal symptoms Y☐ N☐

Number of pregnancies _____ Number of live births _____ History of lactation Y☐ N☐

C☐ P☐ Irregular cycles
C☐ P☐ Bleeding between cycles
C☐ P☐ Heavy flow
C☐ P☐ Clots
C☐ P☐ Painful menses
C☐ P☐ PMS
C☐ P☐ Abnormal PAP
C☐ P☐ Endometriosis
C☐ P☐ Ovarian Cysts
C☐ P☐ Breast pain/tenderness
C☐ P☐ Breast lumps
C☐ P☐ Nipple discharge
C☐ P☐ Breast self-exams
C☐ P☐ Testicular mass
C☐ P☐ Testicular pain
C☐ P☐ Prostate problems
C☐ P☐ Unusual discharge
C☐ P☐ Genital sores
C☐ P☐ Herpes
C☐ P☐ Genital warts
C☐ P☐ Pain with sexual activity
C☐ P☐ Hernia
C☐ P☐ Other sexually transmitted infection