Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

MALE PATIENT HISTORY

Please answer the questions to the best of your ability. Leave blank any questions to which you do not know the answer. If you are uncomfortable with any question, you may leave it blank.

IDENTIFYING INFORMATION

Date of initial appointment:_____ Email:_____

Name:_____ Partner's Name:_____

Address:_____

Telephone Number **Day:**_____ **Evening:**_____

Current Age:_____ Date of Birth:_____ Height:_____ Weight:_____

Partner's Date of Birth:_____

ETHNICITY / CULTURAL BACKGROUND

Circle all that apply:

Asian Indian, Chinese, Filipino, Japanese, Korean, Pakistani or Southeast Asian
Greek, Italian, Middle Eastern, Portuguese or Spanish
Cajun, French Canadian or Jewish
African American, African Descent, Black, Caribbean, Central American, Haitian, Jamaican or Puerto Rican
Hispanic or Mexican
Caucasian
Alaskan Native or American Indian
Other (specify):

EMPLOYMENT

Please describe all current employment including job title, description of responsibilities, duration of employment

_____

_____

_____

FERTILITY EVALUATION

How long have you and your partner been attempting to achieve pregnancy?_____

Have you ever been responsible for any pregnancy in the past? ❑ Yes ❑ No

If so, please indicate: ❑ Same partner ❑ Different partner

Have you had infertility with a previous partner? ❑ Yes ❑ No

If so, please explain:_____

FERTILITY STUDIES

Have you ever had any of the following tests? (Check all that apply)

- ❑ Chlamydia test
- ❑ Chromosome test
- ❑ Hormonal tests (FSH, LH, prolactin, testosterone)
- ❑ Semen analysis
- ❑ Seen a Urologist
- ❑ X-Ray or Ultrasound of testis

Have you ever provided a specimen for an intrauterine insemination for your partner? ❑ Yes ❑ No

If yes, how many attempts:_____

Have you ever provided a specimen for in vitro fertilization for your partner? ❑ Yes ❑ No

Have you ever had any surgery involving any part of the reproductive tract? (Check all that apply)

- ❑ Circumcision
- ❑ Hernia repair
- ❑ Prostate surgery
- ❑ Removal of testis
- ❑ Repair of obstruction of vas deferens
- ❑ Sperm aspiration
- ❑ Testicular biopsy
- ❑ Testicular torsion repair
- ❑ Treatment for undescended testis
- ❑ Varicocele repair
- ❑ Vasectomy
- ❑ Vasectomy reversal
- ❑ Other (specify):_____

Have you ever taken any of the medications listed below:

- ❑ Anabolic steroids
- ❑ Arimidex
- ❑ Chemotherapy
- ❑ Clomiphene citrate
- ❑ hCG (Profasi, Pregnyl)
- ❑ Injectable gonadotropins
- ❑ Prednisone
- ❑ Testosterone or Male hormones
- ❑ Other (specify):_____

How frequently do you and your partner have intercourse per week:_____

or

How frequently do you and your partner have intercourse per month:_____

Have you experienced any difficulties with intercourse? ❑ Yes ❑ No

If yes, please explain:_____

Do you have or have you ever had any of the following (Check all that apply):

- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ Herpes
- ❑ Human Papilloma Virus or Genital warts
- ❑ Mumps with testicular involvement
- ❑ Nongonococcal urethritis
- ❑ Prostatitis
- ❑ Syphilis

REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas? Circle YES or NO below. If YES, please give explanation:

		Patient Comments:	Physician Comments:
Constitutional (good general health lately)	YES / NO		
Eyes	YES / NO		
Ears/Nose/Mouth/Throat	YES / NO		
Cardiovascular (heart/blood vessels/circulation)	YES / NO		
Gastrointestinal (stomach/intestines)	YES / NO		
Genitourinary (genitals/sexual function/kidney/bladder)	YES / NO		
Endocrine (hormones/metabolism/thyroid)	YES / NO		
Integumentary (skin areas and/or breasts)	YES / NO		
Musculoskeletal (bones/joints/muscles)	YES / NO		
Neurological (brain/nervous system)	YES / NO		
Psychiatric (emotions/mood/memory)	YES / NO		
Allergic/Immunologic (allergies/immune system)	YES / NO		
Hematologic/Lymphatic (blood or bleeding problems; lymph nodes or "swollen glands")	YES / NO		

PAST MEDICAL HISTORY

Do you have or have you ever had any of the following (Check all that apply):

- ❑ Anemia
- ❑ Blood transfusion
- ❑ Cancer? (Specify) _____
- ❑ Chronic headaches
- ❑ Cystic Fibrosis
- ❑ Delay of puberty
- ❑ Diabetes
- ❑ Erectile dysfunction
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ Kidney problems
- ❑ Liver problems
- ❑ Mumps with testes involved
- ❑ Testicular tumor
- ❑ Tuberculosis
- ❑ Other _____

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past? ❑ Yes ❑ No

If yes, please indicate date, type, findings of surgery:

_____ _____

_____ _____

MEDICATIONS

Are you allergic to any medications? ❑ Yes ❑ No

If yes, please indicate name of medication and the type of reaction it causes:

Medication	Reaction

Are you currently taking any prescription medications? ❑ Yes ❑ No

If yes, please indicate below:

Medication	Reason

Are you currently taking any over-the-counter medications (including supplements or herbal remedies)? ❑ Yes ❑ No

Medication	Reason

SOCIAL HISTORY

Are you currently married? ❑ Yes ❑ No How long?_____

Do you smoke? ❑ Yes ❑ No If so, how many packs per day?_____ Have you ever smoked? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No If so, how many alcoholic beverages per week?_____

Do you use other recreational drugs? ❑ Yes ❑ No If so, please list:_____

Do you exercise regularly? ❑ Yes ❑ No

If so, please indicate type of exercise and estimate hrs/week spent in this activity.

Type	Hours/week
_____	_____
_____	_____
_____	_____

Have you had a significant change in weight in the past year? ❑ Yes ❑ No

If so, please indicate: ❑ weight gain_____ lbs ❑ weight loss _____lbs.

Do you follow a particular food diet? ❑ Yes ❑ No

❑ Vegetarian ❑ Diet plan name:_____ ❑ Other:_____

Do you use a hot tub or sauna regularly? ❑ Yes ❑ No

EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures:_____

Do you see a counselor? ❑ Yes ❑ No

List any anti-depressant/anti-anxiety medication you are currently taking:_____

Has your infertility produced marital or sexual dysfunction? ❑ Yes ❑ No

Would you like us to refer you to a counselor to discuss your concerns? ❑ Yes ❑ No

FAMILY HISTORY

Have you, your partner or anyone in either of your families had any of the following disorders?

Check all that apply and indicate relationship to you:

a.	Bleeding disorder (hemophilia)	❑ Yes	j.	Neurofibromatosis	❑ Yes
b.	Breast cancer	❑ Yes	k.	Other chromosome abnormality	❑ Yes
c.	Bone or skeletal disease (dwarfism)	❑ Yes	l.	Other nerve/muscle disorder	❑ Yes
d.	Cleft lip/palate	❑ Yes	m.	Ovarian cancer	❑ Yes
e.	Cystic fibrosis	❑ Yes	n.	Polycystic kidney disease	❑ Yes
f.	Down syndrome	❑ Yes	o.	Sickle cell disease	❑ Yes
g.	Heart defect at birth	❑ Yes	p.	Tay Sachs/Canavan disease	❑ Yes
h.	Muscular dystrophy	❑ Yes	q.	Thalassemia	❑ Yes
i.	Neural tube defect (spina bifida, anencephaly)	❑ Yes			

*If yes, please specify who:_____

_____

_____

Form completed by:_____ Relationship to patient:_____

(please print) (write "self" if you are the patient)

Date completed:_____