

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____
Name _____ Partner's Name _____
Address _____
Telephone Number – Day: () _____ Evening: () _____
Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____
Insurance Company _____ Insurance I.D. # _____
Nature of present employment (title, brief description) _____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment – titles, location, brief description, number of years employed:

Are you or have you ever been exposed to any of the following during employment or military service:

- Heat Toxic Fumes Other Specify: _____
 Chemicals Nuclear Radiation _____

III. MEDICAL HISTORY

YES NO

Weight _____ Height _____ Blood Type (if known) _____

Have you lost greater than 20 pounds of weight in the last year?.....

Do you follow a particular food diet or have any special dietary habits?.....

If yes, specify: _____

List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and age you began:

Exercise: _____ Hrs/Week: _____ Age _____ Exercise: _____ Hrs/Week: _____ Age _____

Do you frequently take saunas or steam baths?

Have you ever had surgery in the pelvic area?.....

If yes, specify date and type: _____

Have you ever received X-rays in the pelvic area for therapy or diagnosis ?.....

If yes, explain: _____

Do you have or have you ever had (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cancer? Specify _____ | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Testes Infection |
| _____ | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Testes Injury |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Testes Tumor |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Any Allergies: List _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nongonococcal Urethritis | _____ |

	YES	NO
Have you ever been treated for cancer?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain therapy: _____		
Within the last year, have you taken any prescription medications?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list all prescriptions and problems for which you were taking them:_____		

Are you taking any over-the-counter medications on a regular basis?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list all medications and diagnoses:_____		

Have you had a high fever (over 102°F) during the last 3-4 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you use or have you ever used (check all that apply):		
<input type="checkbox"/> Alcohol – How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____		
<input type="checkbox"/> Cigarettes – Number of packs per day _____		
<input type="checkbox"/> Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____		

IV. SEXUAL HISTORY

	YES	NO
Are you circumcised?.....	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, were both testes descended into the scrotum?	<input type="checkbox"/>	<input type="checkbox"/>
At what age did you begin shaving regularly or start to grow a beard? _____		
How many times have you been married? _____		
Have you ever produced a child with another partner?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how long did it take to produce a child? _____ When was this (dates)? _____		
Have you ever tried to produce a child with another partner?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble getting an erection?	<input type="checkbox"/>	<input type="checkbox"/>
Maintaining an erection?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble with ejaculations?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, <input type="checkbox"/> Premature ejaculations <input type="checkbox"/> Retrograde ejaculations		
Do you feel that some of your ejaculate is deposited in the vagina?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have orgasms without ejaculation during masturbation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any discharge from the penis?	<input type="checkbox"/>	<input type="checkbox"/>
How many times per week do you and your partner now have intercourse? _____		
How many times do you have intercourse around ovulation? _____		
Have you noticed a change in your sexual drive recently?	<input type="checkbox"/>	<input type="checkbox"/>

V. FAMILY HISTORY

	YES	NO
Is there are family history of infertility?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who (list all members and relationship to you): _____		

Is there are history or hormonal disorders in your family?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who and what type: _____		

VI. HISTORY OF INFERTILITY THERAPY

YES NO

Have you been treated for infertility before?

If yes, who was your physician: _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Check all that apply:

- clomiphene citrate (Serophene®, Clomid®)
- hCG (Profasi®, A.P.L. ®)
- hMG (Pergonal®)
- fluoxymeterone (Halotestin®)
- tamoxifen
- GnRH or LHRH (Factrel®)
- testolactone
- urofollitropin or FSH (Metrodin®)
- bromocriptine (Parlodel®)
- Other – Specify _____
- testosterone or Male Hormone
- None

Have you ever had varicocele repair?

If yes, when? _____

Have you ever had reversal or repair?

If yes, when? _____

Have you and your partner ever tried artificial insemination?

If yes, using your sperm? donor sperm?

Have you and your partner ever tried in vitro fertilization?

If yes, when and explain: _____

Which of the following tests have you had performed? Check all that apply and the results if known:

- Semen Analysis When? _____ Results: _____
- Chlamydia Test When? _____ Results: _____
- Mycoplasma Test When? _____ Results: _____
- Antibody Test When? _____ Results: _____
- Hamster Egg Test When? _____ Results: _____
- Chromosome Test When? _____ Results: _____
- Testicular Biopsy When? _____ Results: _____
- X-ray or Ultrasound of Testes When? _____ Results: _____
- Hormonal Test (FSH, LH, prolactin, testosterone) When? _____ Results: _____
- Thyroid Tests When? _____ Results: _____
- Other – Specify _____ When? _____ Results: _____

Is your partner seeing a doctor for evaluation of infertility?

If yes, specify physician name and location: _____

Does the doctor feel that your partner has an infertility problem?

If yes, what is the diagnosis and how is she being treated? _____

Has she ever had children with another man?

If yes, when? _____