SUBMIT

MALE PATIENT HISTORY

Please read all questions carefully and answer as thoroughly as possible.

1. IDENTIFYING INFORMATION:

Date _____

Name _____ Partner's Name _____

Address _____

Telephone Numbers: Home ( )_____ Work ( )_____

Answering Machine @ home? Y N Okay to call @ work? Y N

Date of Birth _____ Age _____ Partner's Date of Birth_____ Age _____

Duration of relationship _____ Duration of infertility _____

Nature of employment (title, brief description)

2. TRAVEL/WORK AND GENERAL BACKGROUND:

Nature of present employment (title, brief description) _____

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

_____ Heat _____ Toxic Fumes _____ Chemicals _____ Nuclear Radiation

_____ Other (please specify) _____

3. MEDICAL HISTORY:

Weight _____ Height _____ Blood Type (if known) _____

Have you gained or lost greater than 20lbs of weight in the past year? Y N

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

If yes, please specify

Do you frequently use saunas, steam baths or whirlpools? Y N

Have you ever had surgery in the pelvic area? Y N

If yes, please specify date and type of all surgeries

Have you ever received x-rays in the pelvic area for therapy or diagnosis Y N

If yes, please specify

Have you ever been treated for cancer? Y N

If yes, explain therapy

Within the past year, have you taken any prescription medicine? Y N

If yes, list all prescriptions & problems for which you were using them:

Are you taking any over-the-counter medications regularly? Y N

If yes, list medications and condition for taking them.

Have you had a high fever *(over 102F)* in the last 3-4 months? Y N

Do you use or have you ever used the following? *(Check all that apply)*

_____ Alcohol- How many glasses per week on average?
Wine _____ Beer _____ Cocktails _____

_____ Cigarettes; # of packs per day _____

_____ Recreational Drug *(marijuana, cocaine, etc.)* current or past

List all forms of vigorous exercise *(swimming, cycling, running, etc.)*

Exercise: Hrs/Week

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

_____ Allergies *(please list and describe reaction)*

_____ Anemia
_____ Appendicitis
_____ Arthritis
_____ Blood Transfusions
_____ Breast Milky Discharge
_____ Breast Tenderness
_____ Cancer-Specify
_____ Chlamydia
_____ Chronic Bronchitis
_____ Chronic Headaches
_____ Colitis
_____ Color Blindness
_____ Diabetes
_____ Dizziness
_____ Epilepsy
_____ Gallbladder
_____ Gonorrhea
_____ Heart Disease
_____ Hepatitis
_____ Herpes
_____ High Blood Pressure
_____ Kidney Infection
_____ Liver problems
_____ Loss of Balance
_____ Measles: German
_____ Measles: Regular
_____ Mumps
_____ Mumps/Testes Involved
_____ Neurological Problems
_____ Nongonococcal Urethritis
_____ Parasitic Infection
_____ Pneumonia
_____ Prostatitis
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Seizures
_____ Syphilis
_____ Testes Infection
_____ Testes Injury
_____ Testes Tumor
_____ Thyroid Problems
_____ Tuberculosis
_____ Ulcers
_____ Visual Disturbances

4. SEXUAL HISTORY

Are you circumcised? Y N

When you were a child, were both testes descended into scrotum? Y N

At what age did you begin shaving regularly or notice a beard? _____

How many times have you been married? _____

Have you produced a child with another partner? Y N

If yes, how long did it take to produce the child? _____

When was this? (Dates) _____

Have you ever tried to produce a child with another partner? Y N
Do you have trouble getting an erection? Y N
Do you have trouble with ejaculations? Y N
If yes, _____ premature ejaculations _____ retrograde ejaculations
Do you feel most of your ejaculate is deposited in the vagina? Y N
Do you ever have orgasms without ejaculations during masturbation? Y N
Do you have any abnormal discharge from the penis? Y N
How many times per week do you and your partner have intercourse?

How many times do you have intercourse around ovulation?

Have you noticed a change in your sexual drive recently? Y N
Have you had an injury to/abnormality of the penis, testicles or prostate? Y N
If yes, when?

Outcome/Result

5. FAMILY HISTORY:
Is there a family history of infertility? Y N
If yes, who? *(List all members and relationship to you)*

Is there a family history of hormonal disorders? Y N
If yes, who and what type?

6. HISTORY OF FERTILITY THERAPY:
Have you ever been treated for infertility before? Y N
If yes, who and what type?

What cause of infertility was diagnosed?

What drugs have you taken for infertility? *(Check all that apply)*

_____ bromocriptine *(Parlodel®)*
_____ clomophine citrate *(Serophene ®, Clomid ®)*
_____ fluoxymesterone *(Halotestine ®)*
_____ GnRH or LHRH *(Factrel ®)*
_____ hCG *(Profasi ®, A.P.L. ®)*
_____ None
_____ hMG *(Pergonal ®)*
_____ tamoxifen
_____ testolactone
_____ testosterone or Male Hormone
_____ urofollitropin or FSH *(Fertinex ® or Metrodin ®)*
_____ Other
(Specify)

Have you ever had a varicocele repair? Y N
If yes, when?

Have you ever had a vasectomy reversal or repair? Y N
If yes, when?

Have you and your partner tried artificial insemination? Y N
If yes, using _____ your sperm _____ donor sperm

Have you and your partner tried in vitro fertilization? Y N
If yes, when and where?

Is your partner currently seeing a doctor for evaluation of infertility? Y N
If yes, doctor name and location

Does this doctor feel that your partner has an infertility problem? Y N
If yes, what is the diagnosis and current treatment?

Has your partner ever conceived a child with another partner? Y N

Which of the following tests have you had performed? *(Check all that apply)*

_____ 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 Assays *(FSH, LH, prolactin, Testosterone)* When? _____ Results? _____
_____ Thyroid Tests When? _____ Results? _____
_____ Other *(specify)* When? _____ Results? _____

Thank you for taking time to complete this form in advance.