

# 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. # \_\_\_\_\_

## II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment - title(s), 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? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you follow a particular food diet or have any special dietary habits? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:		
Exercise: _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age _____		
Do you frequently take saunas or steam baths? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery in the pelvic area? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify date and type of surgery: _____		
Have you ever received X-rays in the pelvic area for therapy or diagnosis? .....	<input type="checkbox"/>	<input type="checkbox"/>
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 Transfusion	<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 Headaches	<input type="checkbox"/> Measles: Regular	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Colitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Mumps with Testes Involved	<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	_____

Have you ever been treated for cancer? .....

If yes, explain therapy: \_\_\_\_\_

Within the last year, have you taken any prescription medications? .....

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? .....

If yes, list all medications and diagnoses: \_\_\_\_\_

\_\_\_\_\_

Have you had a high fever (over 102°F) during the past 3-4 months? .....

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

0 Alcohol - How many glasses per week do you usually drink? Wine \_\_\_\_\_ Beer \_\_\_\_\_ Cocktails \_\_\_\_\_

0 Cigarettes - Number of packs per day \_\_\_\_\_

0 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? .....

When you were a child, were both testes descended into the scrotum? .....

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? .....

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? .....

Do you have trouble getting an erection? .....

Maintaining an erection? .....

Do you have trouble with ejaculations? .....

If yes, 0 Premature ejaculations 0 Retrograde ejaculations?

Do you feel that some of your ejaculate is deposited in the vagina? .....

Do you ever have orgasms without ejaculation during masturbation? .....

Do you have any discharge from the penis? .....

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? .....

**V. FAMILY HISTORY**

**YES NO**

Is there a family history of infertility? .....

If yes, who (list all members and relationship to you): \_\_\_\_\_

\_\_\_\_\_

Is there a history of hormonal disorders in your family? .....

If yes, list who (relationship to you) and what type: \_\_\_\_\_

\_\_\_\_\_

**VI. HISTORY OF FERTILITY 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:

- |                                                                   |                                                            |
|-------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> clomiphene citrate (Serophene®, Clomid®) | <input type="checkbox"/> hCG (Profasi®, A.P.L.®)           |
| <input type="checkbox"/> hMG (Pergonal®)                          | <input type="checkbox"/> fluoxymesterone (Halotestin®)     |
| <input type="checkbox"/> tamoxifen                                | <input type="checkbox"/> GnRH or LHRH (Factrel®)           |
| <input type="checkbox"/> testolactone                             | <input type="checkbox"/> urofollitropin or FSH (Metrodin®) |
| <input type="checkbox"/> bromocriptine (Parlodel®)                | <input type="checkbox"/> Other - Specify _____             |
| <input type="checkbox"/> testosterone or Male Hormone             | <input type="checkbox"/> None                              |

Have you ever had varicocele repair? .....

If yes when? \_\_\_\_\_

Have you ever had vasectomy 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:

- |                                                                            |                            |
|----------------------------------------------------------------------------|----------------------------|
| <input type="checkbox"/> Semen Analysis                                    | When? _____ Results: _____ |
| <input type="checkbox"/> Chlamydia Test                                    | When? _____ Results: _____ |
| <input type="checkbox"/> Mycoplasma Test                                   | When? _____ Results: _____ |
| <input type="checkbox"/> Antibody Test                                     | When? _____ Results: _____ |
| <input type="checkbox"/> Hamster Egg Test                                  | When? _____ Results: _____ |
| <input type="checkbox"/> Chromosome Test                                   | When? _____ Results: _____ |
| <input type="checkbox"/> Testicular Biopsy                                 | When? _____ Results: _____ |
| <input type="checkbox"/> X-ray or Ultrasound of Testes                     | When? _____ Results: _____ |
| <input type="checkbox"/> Hormonal Tests (FSH, LH, prolactin, testosterone) | When? _____ Results: _____ |
| <input type="checkbox"/> Thyroid Tests                                     | When? _____ Results: _____ |
| <input type="checkbox"/> Other - Specify _____                             | When? _____ Results: _____ |

Is your partner currently 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? \_\_\_\_\_