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?	☐	☐
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 the 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 of surgery:_____		
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):

☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Blood Transfusion
☐ Breast Milky Discharge
☐ Breast Soreness
☐ Breast Tenderness
☐ Cancer? Specify_____
_____
☐ Chlamydia
☐ Chronic Bronchitis
☐ Chronic Headaches
☐ Colitis
☐ Cystic Fibrosis
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Gallbladder Problems
☐ Gonorrhea
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Kidney Infection
☐ Liver Problems
☐ Loss of Balance
☐ Measles: German
☐ Measles: Regular
☐ Mumps
☐ Mumps with 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
☐ Any Allergies? List_____
_____

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 fried 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:

☐ clomiphene citrate (Serophene®, Clomid®)
☐ hMG (Pergonal®)
☐ tamoxifen
☐ testolactone
☐ bromocriptine (Parlodel®)
☐ testosterone or Male Hormone
☐ hCG (Profasi®, A.P.L.®)
☐ fluoxymesterone (Halotestin®)
☐ GnRH or LHRH (Factrel®)
☐ urofollitropin or FSH (Metrodin®)
☐ Other - Specify_____
☐ 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:

☐ 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 Tests (FSH, LH, prolactin, testosterone)	When?_____	Results:_____
☐ Thyroid Tests	When?_____	Results:_____
☐ 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?_____		