

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? YES NO

If yes, explain therapy: _____

Within the last year, have you taken any prescription medications? YES NO

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? YES NO

If yes, list all medications and diagnoses: _____

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

Alcohol – How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____

Cigarettes – Number of packs per day _____

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: _____

Tattoo - if yes date _____ Body Piercing - if yes date _____

IV. SEXUAL HISTORY

YES NO

Are you circumcised? YES NO

When you were a child, were both testes descended into the scrotum? YES NO

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? YES NO

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? YES NO

Do you have trouble getting an erection? YES NO

Maintaining an erection? YES NO

Do you have trouble with ejaculations? YES NO

If yes, Premature ejaculations Retrograde ejaculations

Do you feel that some of your ejaculate is deposited in the vagina? YES NO

Do you ever have orgasms without ejaculations during masturbation? YES NO

Do you have any discharge from the penis? YES NO

How many times per week do you and your partner now have intercourse? _____

Have you noticed a change in your sex drive recently? YES NO

V. FAMILY HISTORY

YES NO

Is there a family history of infertility? YES NO

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

Have you lost greater than 20 pounds of weight in the last year? YES NO

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"/> urofollutropin or FSH (Metrodin®) |
| <input type="checkbox"/> bromocriptine (Pariodel®) | <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 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 was the diagnosis and how is she being treated? _____

Has she ever had children with another man?

If yes, when? _____

FOR PHYSICIAN USE ONLY

VII. PHYSICAL FINDINGS

VIII. SURGERY

IX. OTHER COMMENTS

X. COURSE OF ACTION
