

MALE PATIENT HISTORY

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:

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 of surgery: _____

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

If yes, explain: _____

III. MEDICAL HISTORY (CONT.)

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 Problems | <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"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mumps with testes involved | <input type="checkbox"/> Any Allergies: List _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nongonococcal Urethritis | _____ |

YES NO

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 diagnosis _____

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):

- Alcohol – How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____
- Cigarettes – Number of packs per day: _____ If quit, how long since you smoked? _____
- Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician or nurse. 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? _____

IV. SEXUAL HISTORY (CONT.)

YES NO

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, () Premature ejaculations () Retrograde ejaculations?

Have you been diagnosed with 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 abnormal discharge from the penis? () ()

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

How many times do you have intercourse around ovulation? _____

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? _____

VI. HISTORY OF FERTILITY THERAPY (CONT.)

YES NO

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

- | | |
|---|--|
| <input type="checkbox"/> clomiphene citrate (Clomid) | <input type="checkbox"/> hCG (Pregnyl, Profosi) |
| <input type="checkbox"/> recFSH (Follistim, Gonal-f) | <input type="checkbox"/> hMG (Repronex, Humegon, Pergonal) |
| <input type="checkbox"/> hpFSH (Fertinex, Brevelle) | <input type="checkbox"/> bromocriptine (Parlodel) |
| <input type="checkbox"/> tamoxifen | <input type="checkbox"/> fluoxymesterone (Halotestin) |
| <input type="checkbox"/> testolactone | <input type="checkbox"/> other, specify : _____ |
| <input type="checkbox"/> testosterone or male hormone | <input type="checkbox"/> none |
| <input type="checkbox"/> GnRH or LHRH (Factrel) | |

Have you ever had a varicocele repair? () ()
 If yes, when? _____

Have you ever had a 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"/> Hormonal Tests (FSH, LH, prolactin, testosterone) | When? _____ | Results: _____ |
| <input type="checkbox"/> Chromosome Test | When? _____ | Results: _____ |
| <input type="checkbox"/> Hamster Egg Test | When? _____ | Results: _____ |
| <input type="checkbox"/> Testicular Biopsy | When? _____ | Results: _____ |
| <input type="checkbox"/> Antibody Test | When? _____ | Results: _____ |
| <input type="checkbox"/> X-ray or Ultrasound of Testes | When? _____ | Results: _____ |
| <input type="checkbox"/> Mycoplasma Test | When? _____ | Results: _____ |
| <input type="checkbox"/> Thyroid Tests | When? _____ | Results: _____ |
| <input type="checkbox"/> 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? _____