MALE PATIENT HISTORY

IDENTIFYING INFORMATION

Name_____ Date_____
Partner's Name_____
Address_____
Telephone (Day)_____ (cell)_____ (evening)_____
e-mail address_____ Duration of Infertility_____
Date of Birth_____ Partner's Date of Birth_____ Duration of Relationship_____
Insurance Company_____ ID#_____

TRAVEL/WORK AND GENERAL BACKGROUND
All present employment (titles, location, brief description and 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 _____

MEDICAL HISTORY
Weight _____ Height _____ Blood Type (if known)_____
Have you lost greater than 20 pounds in the last year?..... Y N
Do you follow a particular food diet or have any special dietary habits?..... Y N
If yes, specify:_____
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:
Exercise_____Hrs/Week_____ Exercies_____ Hrs/Week_____
Do you frequently take saunas or steam baths?..... Y N
Have you ever had surgery in the pelvic area?..... Y N
If yes, specify date and type of surgery:_____
Have you ever received X-rays in the pelvic area for therapy or diagnosis?..... Y N
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 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?..... Y N
If yes, explain therapy_____
Within the last year, have you taken any prescription medications..... Y N

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?..... Y N

If yes, list all medications and diagnoses_____

_____

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

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_____

_____

SEXUAL HISTORY

Are you circumcised?..... Y N

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

At what age did you begin shaving regularly or start to grown a beard?_____

How many times have you been married?_____

Have you ever produced a child with another partner?..... Y N

If yes, how long did it take to produce a child_____ When was this (date)_____

Have you ever tried to produce a child with another partner..... Y N

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

Maintaining an erection?..... Y N

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

If yes, ___Premature ejaculations, ___ Retrograde ejaculations?

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

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

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

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?..... Y N

FAMILY HISTORY

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

If yes, who (list all members and relationship to you)_____

_____

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

If yes, list who (relationship to you) and what type_____

_____

HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before?..... Y N

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
___ hCH (Profasi, A.P.L.)
___ fluoxymesterone (Halotestin)
___ GnRH or LHRH (Factrel)
___ urofollitropin or FSH (Metrodin)
___ Other _____
___ None

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

Have you ever had vasectomy reversal or repair?..... Y N

If yes, when?_____

Have you and your partner ever tried artificial insemination?..... Y N
If yes, using ___your sperm, ___donor sperm?
Have you and your partner ever tried in vitro fertilization?..... Y N
If yes, when and explain _____

_____

Which of the following tests have you had performed? Check all that apply and the results if know.

___ 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, _____ When_____ Results_____

Is your partner currently seeing a doctor for evaluation of infertility?..... Y N
If yes, specify physician name and location_____

_____

Does the doctor feel that your partner has an infertility problem?..... Y N
If yes, what is the diagnosis and how is she being treated?_____

_____

Has she ever had children with another man?..... Y N
If yes, when_____