Medical Record Number

Patient Name

Addressograph Stamp - Patient Name, Medical Record Number

MALE PATIENT HISTORY

Please answer the questions to the best of your ability. Leave blank any questions to which you do not know the answer. If you are uncomfortable with any question, you may leave it blank.

IDENTIFYING INFORMATION

Date of initial appointment:_____ SSN: _____

Name:_____ Partner's Name: _____

Address: _____

Telephone Number - Day:_____ Evening: _____

Current Age:_____ Date of Birth:_____ Height:_____ Weight:_____ Partner's Date of Birth: _____

EMPLOYMENT

Please describe all current employment including job title, description of responsibilities, duration of employment

_____

_____

_____

FERTILITY EVALUATION

1. How long have you and your partner been attempting to achieve pregnancy? _____

2. Have you ever been responsible for any pregnancy in the past? ❑ Yes ❑ No
   If so, please indicate: ❑ Same partner ❑ Different partner

FERTILITY STUDIES

1. Have you ever had any of the following tests? (Check all that apply.)
   - ❑ Semen analysis
   - ❑ Chlamydia test
   - ❑ Mycoplasma / Ureaplasma culture
   - ❑ Testicular biopsy
   - ❑ Chromosome test
   - ❑ Hamster egg penetration test
   - ❑ Hormonal tests (FSH, LH, prolactin, testosterone)
   - ❑ X-ray or ultrasound of testis

2. Have you ever provided a specimen for an intrauterine insemination for your partner? ❑ Yes ❑ No
   If yes, when? _____

3. Have you ever had any surgery involving any part of the reproductive tract? (Check all that apply.)
   - ❑ Varicocele repair
   - ❑ Vasectomy reversal
   - ❑ Hernia repair
   - ❑ Testicular torsion repair
   - ❑ Testicular biopsy
   - ❑ Sperm aspiration
   - ❑ Vasectomy
   - ❑ Repair of obstruction of vas deferens
   - ❑ Prostate surgery
   - ❑ Removal of testis
   - ❑ Other (specify) _____

4. Have you ever had any significant testicular injury? ❑ Yes ❑ No
   If yes, please describe

_____

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4. Have you ever had any significant testicular injury? ❑ Yes ❑ No
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_____

5. Have you ever taken any of the medications listed below:

❑ clomiphene citrate
❑ injectable gonadotropins
❑ anabolic steroids
❑ bromocriptine (Parlodel or Dostinex)
❑ hCG (Profasi, Pregnyl)
❑ testosterone or male hormones
❑ prednisone
❑ other (specify) _____

6. How frequently do you and your partner have intercourse:_____per week/month

7. Have you experienced any difficulties with intercourse that may be contributing to infertility?

❑ Yes ❑ No If yes, please explain: _____

_____

8. Do you have or have you ever had any of the following (Check all that apply)

❑ chlamydia
❑ gonorrhea
❑ nongonococcal urethritis
❑ herpes
❑ Human Papilloma Virus or genital warts
❑ mumps with testicular involvement
❑ prostatitis
❑ syphilis

REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas? Circle YES or NO below. If YES, please give explanation:

		Patient Comments:	Physician Comments:
Constitutional (good general health lately)	YES / NO		
Eyes	YES / NO		
Ears/Nose/Mouth/Throat	YES / NO		
Cardiovascular (heart/blood vessels/circulation)	YES / NO		
Gastrointestinal (stomach/intestines)	YES / NO		
Genitourinary (genitals/sexual function/kidney/bladder)	YES / NO		
Neurological (brain/nervous system)	YES / NO		
Integumentary (skin areas and/or breasts)	YES / NO		
Psychiatric (emotions/mood/memory)	YES / NO		
Musculoskeletal (bones/joints/muscles)	YES / NO		
Endocrine (hormones/metabolism/thyroid)	YES / NO		
Allergic/Immunologic (allergies/immune system)	YES / NO		
Hematologic/Immunologic (blood or bleeding problems: lymph nodes or "swollen glands")	YES / NO		

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PAST MEDICAL HISTORY

Do you have or have you ever had any of the following (Check all that apply)

❑ Anemia
❑ Appendicitis
❑ Arthritis
❑ Breast disease
❑ Blood transfusion
❑ Breast discharge
❑ Chronic bronchitis
❑ Chronic headaches
❑ Cancer? (Specify)_____
❑ Cystic Fibrosis
❑ Delay of puberty
❑ Diabetes
❑ Dizziness
❑ Gallbladder disease
❑ Heart disease
❑ Hepatitis
❑ High blood pressure
❑ Kidney problems
❑ Liver problems
❑ Loss of balance
❑ Measles: German
❑ Measles: regular
❑ Mumps
❑ Mumps with testes involved
❑ Neurological problems
❑ Pneumonia
❑ Rheumatic fever
❑ Scarlet fever
❑ Seizures
❑ Testicular tumor
❑ Tuberculosis
❑ Visual problems
❑ Other _____

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past? ❑ Yes ❑ No

If yes, please indicate date, type, findings of surgery:

_____ _____

_____ _____

MEDICATIONS

Are you allergic to any medications? ❑ Yes ❑ No If yes, please indicate name of medication and type of reaction it causes.

Medication	Reaction

Are you currently taking any prescription medications? ❑ Yes ❑ No If yes, please indicate below:

Medication	Reason

Are you currently taking any over-the-counter medications? ❑ Yes ❑ No

Medication	Reason

PAST MEDICAL HISTORY

Do you have or have you ever had any of the following (Check all that apply)

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Medication	Reason

Are you currently taking any over-the-counter medications? ❑ Yes ❑ No

Medication	Reason

SOCIAL HISTORY

Are you currently married?_____If so, how long?_____Have you previously been married? _____
Do you smoke?_____If so, how many packs per day? _____
Do you drink alcohol?_____If so, how many alcoholic beverages per week? _____
Have you ever used illicit (illegal) drugs?_____If so, please list _____
Do you exercise regularly?_____If so, please indicate type of exercise and estimate hrs/week spent in this activity.

Type	Hours/week
_____	_____
_____	_____
_____	_____

Have you had a significant weight change in the last year? ❑ Yes ❑ No
If so, please indicate: ❑ weight gain_____lbs ❑ weight loss_____lbs
Do you follow a particular food diet? ❑ Yes ❑ No
Vegetarian ❑ diet plan name:_____ ❑ other _____

FAMILY HISTORY

Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you:

Illness	Relationship to you:
❑ diabetes	_____
❑ high blood pressure	_____
❑ heart disease	_____
❑ breast cancer	_____
❑ ovarian cancer	_____
❑ colon cancer	_____
❑ prostate cancer	_____
❑ other	_____

Form completed by:_____Relationship to patient: _____
(please print) (write *self* if you are the patient)

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however, the questionnaire may be referenced for additional details.

_____ _____
(Attending Physician Signature) (Date)

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Are you currently married?_____If so, how long?_____Have you previously been married? _____ Do you smoke?_____If so, how many packs per day? _____
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Type	Hours/week
_____	_____
_____	_____
_____	_____

Have you had a significant weight change in the last year? ❑
Yes ❑ No If so, please indicate: ❑
weight gain_____lbs ❑ weight loss_____lbs Do you follow a particular food diet?
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