



MALE PATIENT HISTORY

Name \_\_\_\_\_ Partner's Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_

What is your primary problem today? \_\_\_\_\_

Relationship Duration \_\_\_\_\_ Duration of unprotected intercourse \_\_\_\_\_

Who is your physician? \_\_\_\_\_ Who sent you to us? \_\_\_\_\_

MEDICAL HISTORY

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type \_\_\_\_\_ Any recent changes in your weight? \_\_\_\_\_

Are you or have you ever been exposed to any of the following during employment or military service:

Heat Toxic Fumes Chemicals Nuclear Radiation Other Specify:

Do you ever take hot baths or use hot tubs? Yes No If yes, how often? \_\_\_\_\_

Have you ever received X-rays in the pelvic area for therapy or diagnosis? Yes No

If yes, explain: \_\_\_\_\_

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

- Anemia, Chronic Bronchitis, Hepatitis, Mental Problems, Seizures, Anesthesia reaction, Chronic Headaches, High Blood Pressure, Migraine, Serious Injury, Appendicitis, Colitis, Immunizations: Mitral Valve Prolapse, Syphilis, Arthritis, Color Blindness, German Measles, Mumps, Thyroid Problems, Asthma, Depression, Hepatitis, Mumps in testes, Tuberculosis, Bladder Infections, Diabetes, Influenza, Neurological Problems, Ulcers, Blood Clot, Dizziness, Kidney Disease, Parasitic Infection, Visual Disturbances, Blood Transfusions, Epilepsy, Liver Problems, Pneumonia, Weight Loss, Breast Milky Discharge, False teeth, Loss of Balance, Poor Sense of Smell, Weight Gain, Breast Soreness, Gallbladder Problems, Low Blood Pressure, Prostatitis, Breast Tenderness, Heart Disease, Measles: German, Rheumatic Fever, Cancer (Specify), Heart murmur, Measles: (Age?), Scarlet Fever

Any Allergies: List \_\_\_\_\_

Have you ever had surgery? Yes No If yes, explain \_\_\_\_\_

Have you taken prescription medications in the past year? Yes No If yes, explain \_\_\_\_\_

Are you taking any over-the-counter medications? Yes No If yes, explain \_\_\_\_\_

Have you been evaluated by a urologist (male specialist) Yes No If yes, who? \_\_\_\_\_

Have you had a high fever (over 102°F) during the past 3-4 months? Yes No

Do you use vitamin or herbal therapies?

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

Caffeine - How many cups per day? \_\_\_\_\_

Alcohol- How many glasses per week do you usually drink? \_\_\_\_\_

Cigarettes - Number per day \_\_\_\_\_

Recreational Drugs (Marijuana, Cocaine, etc.) \_\_\_\_\_

**SEXUAL HISTORY**

How many months have you been trying to conceive? \_\_\_\_\_ How many has the timing been good? \_\_\_\_\_

As a child, did u have any surgery involving the testicles? Yes No

Specify \_\_\_\_\_

Have you ever had a pregnancy with another partner? Yes No

Do you have trouble getting/maintaining an erection? Yes No

Specify \_\_\_\_\_

Do you have any trouble with ejaculation? Yes No

Specify \_\_\_\_\_

Do you have any discharge from your penis? Have you ever been treated for any STD's? Yes No

Specify \_\_\_\_\_

**FAMILY HISTORY**

What is your ethnic origin? Country \_\_\_\_\_ Ethnicity \_\_\_\_\_

Number of brothers \_\_\_\_\_ sisters \_\_\_\_\_ Is there a family history of infertility? Yes No

Explain \_\_\_\_\_

**HISTORY OF FERTILITY THERAPY**

Have you been treated for infertility before? Yes No

Specify \_\_\_\_\_

What drugs have you taken for infertility? \_\_\_\_\_

Have you ever had a varicocele/ vasectomy reversal or repair? Speciy \_\_\_\_\_

Have you had any tests performed?. If yes Specify \_\_\_\_\_