REPRODUCTIVE HEALTH CENTER

Male Patient History

Date: _____

I. Identifying Information

Name _____ Partner's Name _____

Address _____

Telephone Home _____

Mobile _____

Work

Date of Birth _____ Partner's Date of Birth _____

Duration of Relationship _____ Duration of Infertility _____

Nature of present employment (title, brief description) _____

Insurance Company _____

Insurance ID _____ Group # _____

Responsible Party _____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment - title(s), location, brief description, number of years employed

1 _____

2 _____

3 _____

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

Excessive heat ☐

Toxic Fumes ☐

Chemicals ☐

Nuclear Radiation ☐

Other ☐

Specify _____

None of the above ☐

III. Medical History

Weight _____ Height _____ Blood Type (if known) _____

Have you lost greater than 20 pounds in the last year? _____

Do you follow a particular food plan or have any special dietary habits? _____

If **yes**, specify:

List the forms and frequency of regular vigorous exercise (cycling, running, swimming, etc.) and age at which you began the activity:

Activity	**Hours per 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 _____

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

	When?	Results?
Semen Analysis		
Chlamydia Test		
Mycoplasma Test		
Antibody Test		
Hamster Egg Test		
Chromosome Test		
Testicular Biopsy		
X-ray or Ultrasound of Testes		
Hormonal Tests (FSH,LH,prolactin,testosterone)		
Thyroid Tests		
Other- Specify		

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, how is she being treated? _____

Has she ever had children with another man? _____

If yes, when? _____

ARE YOU ALLERGIC TO ANY MEDICATION? _____

If **yes**, please list medications to which you are allergic and describe the reaction you have to each.

Medication	**Reaction**	**Medication**	**Reaction**
Example: Benadryl	*Hives*		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received X-rays to the pelvic area for therapy or diagnosis? _____

If **yes**, explain: _____

Do you have or have you eve had (check all that apply)

__ Anemia
__ Anorexia
__ Appendicitis
__ Arthritis
__ Bladder Infections
__ Blood Transfusions
__ Breast Milky Discharge
__ Breast Soreness
__ Breast Tenderness
__ Cancer
Specify:_____
__ Chest Pain
__ Chlamydia
__ Chronic Bronchitis
__ Chronic Headaches
__ Colitis
__ Color Blind
☐ Diabetes
__ Dizziness
__ Epilepsy
__ Gallbladder Problems
__ Gonorrhea
__ Heart Disease
__ Hepatitis
Type? _____
__ Herpes
__ Hirsutism (excess hair growth)
__ High Blood Pressure
__ Immunizations for German Measles
__ Kidney Infection
__ Liver Problems
__ Loss of Balance
__ Lupus
__ Measles, German
__ Measles, Regular
__ Neurological Problems
__ Nongonococcal Urethritis
__ Parasitic Infection
__ Pneumonia
__ Poor Sense of Smell
__ Problems with Skin Pigmentation
__ Rheumatic Fever
__ Scarlet Fever
__ Seizures
__ Spastic Colon
__ Syphilis
__ Thyroid Problems,
Type? _____
__ Tuberculosis
__ Ulcers
__ Visual Disturbances
__ Vitiligo

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.

Ex. lisinopril – high blood pressure _____ _____

_____ _____ _____

_____ _____ _____

Are you taking any over-the-counter medications on a regular basis? _____

Ex. Low dose aspirin – high blood pressure

_____ _____ _____

_____ _____ _____

Have you had a high fever (over 102 degrees F) during the past 3-4 months? _____

If Yes, Specify When: _____

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

__ Alcohol About how many ounces per week? _____

__ Cigarettes How long? _____ Number of packs per day? _____

__ Recreational Drugs (*marijuana, cocaine, etc.*)

IV. SEXUAL HISTORY

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? _____

Have you ever produced a child with another partner? _____

If yes, how long did it take to produce a child? _____

Have you ever tried to produce a child with another partner _____

Do you have trouble achieving and maintaining an erection? _____

Do you have trouble with ejaculations? _____

If yes, _____

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 discharge from the penis? _____

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? _____

V. FAMILY HISTORY

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

Have you been treated for infertility before? _____

If yes, who was your physician? _____

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

__ hMG
__ Progesterone
__ Antibiotics
__ Clomiphene citrate (Clomid)
__ Bromocriptine (Parlodel)
__ Follistim/Gonal-F or FSH
__ Estrogens
__ Prednisone (or cortisone like drugs)
__ GnRH or LHRH (Factrel)
__ hCG (Ovidrel.)
__ Letrozole (femara)
__ Other, specify:

Have you ever had varicocele repair? _____

If yes, when? _____

Have you ever 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? _____