REPRODUCTIVE HEALTH CENTER
MALE PATIENT HISTORY

I. 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, if present_____

Insurance Company_____ Insurance I.D.#_____

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 __Chemicals

__Toxic Fumes __Nuclear Radiation

Other Specify:_____

III. MEDICAL HISTORY

Weight_____ Height_____ BloodType(if known)_____

Have you lost greater than 20 pounds of weight in the last year? yes no

Do you follow a particular food diet or

have any special dietary habits? yes no

If yes, specify:_____

List the forms and frequency of regular vigorous exercise (swimming,cycling,running) and the age you began them:

Exercise_____ Hrs/wk_____ Age____ Exercise_____ Hrs/wk_____ Age____

Do you frequently take saunas or steam baths? yes no

Have you ever had surgery in the pelvic area? yes no

If yes, specify date and type of surgery:_____

Which of the following tests have you had performed?

Check all that apply and the results:

Semen Analysis	When?	Results:
Chalmydia 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- Specify	When?	Results:

Is your partner currently seeing a doctor for evaluation of infertility? yes no

If yes, specify physician name and location:_____

Does the doctor feel that your partner has an infertility problem? yes no

If yes, how is she being treated?_____

Has she ever had children with another man? yes no

If yes, when?_____

Do you have any allergies to any medications? yes no

If yes, what reactions do you have? Please list.

_____

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
__Anorexia
__Appendicitis
__Arthritis
__Asthma
__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
__Endometriosis
_____

__Epilepsy
__Gallbladder Problems
__Gonorrhea
__Heart Disease
__Hepatitis Type?
__Herpes
__Hirsutism (Excess Hair Growth)
__High Blood Pressure
__Immunization:German Measle
__Kidney Infection
__Liver Problems
__Loss of Balance
__Lupus
__Measles:German
__Measles:Regular
__Neurological Problems
__Nongonococcal Urethritis
__Ovarian Cysts
Any Allergies: Please list:
_____

__Parasitic Infection
__Pelvic Infection
__Pneumonia
__Poor Sense of Smell
__Problems with Skin Pigmentation
__Rheumatic Fever
__Scarlet Fever
__Seizures
__Spastic Colon
__Syphilis
__Thyroid Problems? Type?_____
__Tuberculosis
__Ulcers
Vaginitis: Trichomoniasis
Yeast, # of episodes: _____
__Visual Disturbances
__Vitiligo
_____

Have you ever been treated for cancer?

If yes, explain therapy:_____

Within the last year, have you taken any prescription medications? yes no

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? yes no

If yes, list all medications and diagnoses:

_____

Have you had a high fever (over 102 degrees F)
during the past 3-4 months? yes no

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 _____ How long have you smoked?_____

Recreational Drugs (Marijuana, Cocaine, others)_____

IV. SEXUAL HISTORY

Are you circumcised? yes no

When you were a child, were both testes descended into the scrotum? yes no

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? yes no

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

Have you ever tried to produce a child with another partner? yes no

Do you have trouble achieving and maintaining an erection? yes no

Do you have trouble with ejaculations? yes no

If yes, __Premature ejaculations __Retrograde ejaculations?

Do you feel that some of your ejaculate is deposited in the vagina? yes no

Do you ever have orgasms without ejaculation during masturbation? yes no

Do you have any discharge from the penis? yes no

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? yes no

V. FAMILY HISTORY

Is there a family history of infertility? yes no

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

_____

Is there a history of hormonal disorders in your family? yes no

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

_____

VI. HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before? yes no

If yes, who was your physician?_____

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

__clomiphene citrate (Serophene, Clomid)
__hMG (Pergonal)
__tamoxifen
__testolactone (Metrodin)
__bromocriptine (Parlodel)
__testosterone or Male Hormone
__hCG (Profasi, A.P.L.)
__fluoxymesterone (Halotestin)
__GnRH or LHRH (Factrel)
__urofollitropin or FSH
__None
Other:_____

Have you ever had varicocele repair? yes no

If yes, when?

_____

Have you ever had vasectomy reversal or repair? yes no

If yes, when?

_____

Have you and your partner ever tried artificial insemination? yes no

If yes: using your sperm? donor sperm?

_____

Have you and your partner ever tried in vitro fertilization? yes no