MALE PATIENT HISTORY

Reset Form

I.IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Address _____

Date of Birth _____ Partner's Date of Birth _____

Duration of Relationship _____ Duration of Infertility _____

II.TRAVEL/WORK AND GENERAL BACKGROUND

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

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

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

- ☐ Heat
- ☐ Chemicals
- ☐ Toxic Fumes
- ☐ Nuclear Radiation
- ☐ Other, specify: _____
- ☐ _____

II.MEDICAL HISTORY

	YES	NO
Weight _____ Height _____ Blood Type (if known) _____		
Have you lost greater than 20 pounds of weight in the last year?	☐	☐
Do you follow a particular food diet or have any special dietary habits?	☐	☐
If yes, specify _____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began.		
Exercise: _____ Hrs/Week: _____Age:_____		
Exercise: _____ Hrs/Week: _____Age:_____		
Do you frequently take saunas or steam baths?	☐	☐
Have you ever had surgery in the pelvic area?	☐	☐
If yes, specify _____		
Have you ever received X-rays in the pelvic area for therapy or diagnosis?	☐	☐
If yes, explain _____		

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

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood Transfusion
- ☐ Breast Milky Discharge
- ☐ Breast Soreness
- ☐ Breast Tenderness
- ☐ Cancer? Specify_____ _____
- ☐ Chlamydia
- ☐ Chronic Bronchitis
- ☐ Chronic Headache
- ☐ Colitis
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gallbladder Problems
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Loss of Balance
- ☐ Measles: German
- ☐ Measles: Regular
- ☐ Mumps
- ☐ Mumps w/ 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 _____

	YES	NO
Have you ever been treated for cancer?	☐	☐
If yes, explain therapy _____		
Within the last year have you taken any prescriptions medications?	☐	☐
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?	☐	☐
If yes, list all medications and diagnosis: _____		
_____		
Have you had a high fever (over 102°F) during the past 3-4 months?	☐	☐

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 _____

_____

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? _____ When was this (dates)? _____		
Have you ever *tried* to produce a child with another partner?	☐	☐
Do you have trouble getting an erection?	☐	☐
Maintaining an erection?	☐	☐
Do you have trouble with ejaculations?	☐	☐
If yes, ☐ premature ejaculations ☐ retrograde ejaculations		
Do you feel that some of your ejaculate is deposited in the vagina?	☐	☐
Do you 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 disorder in your family?	☐	☐
If yes, list who (relationship to you) and what type: _____		
_____		

VI. HISTORY OF FERTILITY THERAPY

	YES	NO
Have you been treated for infertility before?	☐	☐

If yes, who was the physician?_____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility (check all that applies):

- ☐ Clomiphene citrate (Serophene®, Clomid®)
- ☐ Hmg (Pergonal®)
- ☐ Tamoxifen
- ☐ Testolactone
- ☐ Bromocriptine (Parlodel)
- ☐ Testosterone or male hormone
- ☐ Hcg (Profasi®, A.P.L®)
- ☐ Fluxymesterone (Halotestin®)
- ☐ GnRH or LHRH (Factrel)
- ☐ Urofollitropin or FSH (Metrodin)
- ☐ Other-Specify: _____
- ☐ None

Have you ever had varicocele repair?	☐	☐

If yes, when? _____

Have you ever had a vasectomy reversal or repair?	☐	☐

If yes, when? _____

Have you or your partner ever tried artificial insemination?	☐	☐

If yes, using ☐ your sperm? ☐ donor sperm?

Have you or your partner ever tried in vitro fertilization?	☐	☐

If yes, when and explain _____

_____

Which of the following test have you performed? Check all that apply and the results if known:

- ☐ 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?_____
- ☐ Hormone Tests (FSH, LH, prolactin, testosterone) — When? _____ Results?_____
- ☐ Thyroid Test — When? _____ Results?_____
- ☐ Other, Specify: — When? _____ Results?_____

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VII. PHYSICAL FINDINGS

VIII. SURGERY

IX. OTHER COMMENTS

X. COURSE OF ACTION