

Confidential Questionnaire - MALE HISTORY

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NAME	AGE	DATE OF BIRTH	SSN
ETHNICITY: <input type="checkbox"/> ASIAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> UNKNOWN			
REFERRED TO A FERTILITY CENTER BY:		MAIN REASON FOR THIS VISIT:	

MARITAL/RELATIONSHIP HISTORY

HAVE YOU BEEN MARRIED PREVIOUSLY OR IN A PREVIOUS RELATIONSHIP? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HOW LONG?
HAVE YOU EVER ACHIEVED A PREGNANCY WITH A PRIOR PARTNER? <input type="checkbox"/> YES <input type="checkbox"/> NO	PLEASE LIST OUTCOME OF ANY PREGNANCIES

PRIOR FERTILITY WORKUP

HAVE YOU HAD ANY OF THE FOLLOWING? IF YES, PLEASE INDICATE THE DATE, THE PHYSICIAN WHO PERFORMED THE TEST, & RESULTS

	Y	N	DATE	RESULT	PHYSICIAN
SEMEN ANALYSIS					
SPERM PENETRATION ASSAY					
UROLOGICAL EXAM					
LAB TESTS					
SURGERIES					
MEDICATIONS					
PRIOR FERTILITY DIAGNOSIS: (If you have been given a diagnosis or suspected diagnosis by another physician, please list here)					

MEDICATION HISTORY

WHAT MEDICATIONS ARE YOU TAKING NOW? (Please list all prescription, over-the-counter, herbal products, enhancements, supplements and/or vitamins that you currently take. Include the amount and how often.)
WHAT MEDICATIONS HAVE YOU TAKEN IN THE PAST? (Please list all prescription, over-the-counter, herbal products, enhancements, supplements and/or vitamins that you have taken. Include the amount and how often.)

MEDICAL HISTORY

WEIGHT:	HEIGHT:	MAXIMUM WEIGHT: WHEN?	MINIMUM WEIGHT: WHEN?	DOES YOUR WEIGHT FLUCTUATE? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE ANY SIGNIFICANT MEDICAL PROBLEMS OR SERIOUS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DESCRIBE:		
ARE YOU ALLERGIC TO ANY MEDICATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST NAME AND REACTION IT CAUSES:		
ANY OTHER ALLERGIES? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST NAME AND REACTION IT CAUSES:		
ANY PAST SURGERIES? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST WITH DATES:		
FREQUENCY OF INTERCOURSE PER WEEK?		ANY DIFFICULTIES WITH INTERCOURSE? IF YES, DESCRIBE: <input type="checkbox"/> YES <input type="checkbox"/> NO		
ANY DIFFICULTIES WITH EJACULATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		DO YOU USE LUBRICANTS? IF YES, DESCRIBE:	ARE YOU EXPOSED TO EXCESSIVE HEAT? (hot baths, sauna, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN:	

MEDICAL HISTORY CONTINUED			
DO YOU CURRENTLY SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HOW MUCH?	HAVE YOU SMOKED MORE THAN 100 CIGARETTES IN THE LAST 3 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU SMOKED MORE THAN 100 CIGARETTES IN YOUR LIFETIME? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HOW MANY DRINKS PER WEEK?		
DO YOU USE RECREATIONAL DRUGS NOW? IF YES, PLEASE LIST: <input type="checkbox"/> YES <input type="checkbox"/> NO	DID YOU USE RECREATIONAL DRUGS IN THE PAST? IF YES, PLEASE LIST: <input type="checkbox"/> YES <input type="checkbox"/> NO		
DO YOU USE ANY CAFFEINE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST:		
DO YOU EXERCISE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST TYPE OF EXERCISE AND HOW OFTEN:		
ANY RISK FACTORS FOR HIV OR INFECTIOUS DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, describe:	HAVE YOU EVER USED INJECTABLE STREET DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU EVER HAD SAME-SEX SEXUAL RELATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU EVER HAD A BLOOD TRANSFUSION? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, when?	ARE YOU A HEMOPHILIAC? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU LIVED OVERSEAS? <input type="checkbox"/> YES <input type="checkbox"/> NO Where? For how long?	
ANY HISTORY OF DIABETES? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY HISTORY OF HIGH BLOOD PRESSURE? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY HISTORY OF STRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ANY EXPOSURE TO ENVIRONMENTAL TOXINS/ CHEMICALS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN:			

FAMILY HISTORY

HAVE ANY OF YOUR RELATIVES HAD ANY HEALTH PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:
DID YOUR RELATIVES HAVE PROBLEMS WITH FERTILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:
ANY HISTORY OF CANCER? <input type="checkbox"/> YES <input type="checkbox"/> NO WHICH RELATIVE?	

	AGE	HEALTH, IF LIVING	CAUSE OF DEATH/IF DECEASED
FATHER			
MOTHER			
SIBLINGS / NAMES:			

Thank you for taking the time to fill out this questionnaire.

PLEASE USE THE SPACE BELOW TO ADD ANYTHING (NOT MENTIONED ABOVE)
THAT YOU FEEL IS IMPORTANT TO YOUR HISTORY AND CARE