Male Reproduction Patient History Form

Many men will have decreased fertility for unknown reasons. By completing this comprehensive history form, you will increase my chances of identifying any factors that contribute to your decreased male fertility.

Identification Date:________________

1. Patient's Name (last, first):	1.1. Wife's Name (last, first):
2. Patient's Primary Physician:	2.1. Wife's Ob/Gyn:
3. Patient's Age:	3.1. Wife's Age:

Fertility History

Male	Female
How many months have you been trying to achieve pregnancy with current partner? ____	Have you ever been pregnant? ( ) Yes ( ) No If Yes, ( ) current partner ( ) previous partner
Have you ever achieved a pregnancy in the past? ( ) Yes ( ) No If Yes, ( ) current partner ( ) previous partner	If you achieved a pregnancy with a previous partner, did it occur after a prolong attempt? ( ) Yes ( ) No
Years of all previous pregnancies: ____________________________________ ( ) Not applicable	Years of all previous pregnancies: ____________________________________ ( ) Not applicable
Outcome of pregnancy: ( ) Normal delivery or Caesarean section ( ) Spontaneous abortion ( ) Induced abortion ( ) Ectopic pregnancy ( ) Premature birth ( ) Stillbirth ( ) Birth defects If live birth delivery, age of children: _________	Outcome of pregnancy: ( ) Normal delivery or Caesarean section ( ) Spontaneous abortion ( ) Induced abortion ( ) Ectopic pregnancy ( ) Premature birth ( ) Stillbirth ( ) Birth defects If live birth delivery, age of children: _________
Has anyone in your family experienced problems with infertility? ( ) Yes ( ) No	Has anyone in your family experienced problems with infertility? ( ) Yes ( ) No
Have you been previously evaluated for infertility? ( ) Yes ( ) No If Yes, Name of physician: _____________________ Year of Evaluation: _____________________	Have you initiated an infertility workup? ( ) Yes ( ) No If Yes, which tests were performed? ( ) Pelvic ultrasound ( ) Histerosalpingogram ( ) Laparoscopy ( ) Basal body temperature ( ) Urinary ovulation monitoring ( ) Cervical mucus testing ( ) Endometrial biopsy ( ) Blood test for hormones

With your current partner, how many months have you used contraception methods? _____	What diagnosis have you been given? ( ) Fertile ( ) Irregular ovulation ( ) Blocked fallopian tubes ( ) Endometriosis ( ) Uterine fibroids ( ) Abnormal cervical mucus or opening ( ) Poor uterine support for pregnancy Other: ___________________________
What has been your most recent form of contraception? ( ) Condom ( ) Pills ( ) Diaphragm ( ) Foam ( ) IUD ( ) Rhythm	Are you currently receiving or plan to receive infertility treatment? ( ) No ( ) Antibiotic treatment ( ) Hormonal replacement ( ) Ovulation stimulation ( ) Laparoscopic lysis of adhesions ( ) Laparoscopic ovarian surgery ( ) Fallopian tube surgery ( ) Intrauterine insemination ( ) Invitro fertilization
	Do you have any non-fertility related health problems? ( ) Yes ( ) No Are you taking any non-fertility related medication? ( ) Yes ( ) No

Sexual History

Do you have problems with sexual desire? ( ) Yes ( ) No	Do you use lubrication with intercourse? ( ) Yes ( ) No
Do you have problems with erections? ( ) Yes ( ) No If Yes, ( ) Problems getting or maintaining erections ( ) Premature ejaculation If Yes, how long does intercourse last before ejaculation? ____________ (in minutes) Are early morning erections good? ( ) Yes ( ) No Are erections with masturbation good? ( ) Yes ( ) No	Have you ever had white, green or yellow discharge from the end of your penis? ( ) Yes ( ) No Have you ever had pain and inflammation in your testicles? ( ) Yes ( ) No Have you ever had a urinary tract infection? ( ) Yes ( ) No Has your partner had problems with recurrent vaginal infections? ( ) Yes ( ) No
Do you have problems with ejaculation? ( ) Yes ( ) No If Yes, ( ) Dry ejaculation ( ) Low volume ejaculation ( ) Painful ejaculation ( ) Bloody ejaculation ( ) Other: _________________________	Has you or your partner had any of the following diseases? ( ) Yes ( ) No ( ) Herpes ( ) Pelvic inflammatory disease ( ) Venereal disease ( ) Gonorrhea ( ) Urethritis ( ) Syphilis ( ) HIV ( ) Condyloma

General Medical History

Have you had any major illness in the last 12 months? ( ) Yes ( ) No If Yes, have you had or does it include the following illnesses? ( ) Allergies ( ) Bowel disorder, including Ulcers ( ) Bleeding disorders ( ) Cancer ( ) Diabetes ( ) Heart problems, including hypertension ( ) Hepatitis ( ) Thyroid disease ( ) Mumps ( ) Kidney failure ( ) Nervous system disease ( ) Other: ______________________________	Please list all medication you have taken continually (over a 2 week period) in the last year. Please include vitamins and body shaping supplements: ______________________________________ ______________________________________ ______________________________________ ______________________________________
Have you ever had an operation for: ( ) Hernia ( ) Varicocele ( ) Hydrocele ( ) Undescended testis ( ) Testis biopsy ( ) Vasectomy ( ) Other: ______________________________	Do you smoke? ( ) Yes ( ) No If Yes, ( ) less than an half pack a day ( ) a pack a day What is your alcohol consumption? ( ) None ( ) Occasional drink once a week ( ) A drink every day ( ) Multiple drinks during any given day (binge drinking)
At work, are you exposed to: ( ) Pesticides ( ) Industrial solvents ( ) Radiation ( ) Plastics	Have you ever taken recreational drugs in the last 15 years? ( ) Yes ( ) No
Was your mother given diethylstillbesterol (DES) during her pregnancy with you? ( ) Yes ( ) No	Do any of your brothers have fertility problems? ( ) Yes ( ) No ( ) No brothers Any family members with Cystic fibrosis (disease causing secretions in the lungs)? ( ) Yes ( ) No ( ) I don't know
Do you have or have had problems with: ( ) Headaches ( ) Visual problems ( ) Growth problems ( ) Breast enlargement or tenderness ( ) Recent weight gain – greater than 20 lbs in last 6 months	Do you urinate without straining? ( ) Yes ( ) No Do you have a good urine flow rate? ( ) Yes ( ) No Do you have problems with frequency during the day or night? ( ) Yes ( ) No