HEARTLAND CENTER FOR REPRODUCTIVE MEDICINE
ENDOCRINOLOGY – FERTILITY
MALE

PERSONAL DATA SSN # _____

Name _____ Age _____ Date of birth _____

Address _____ Home phone _____

_____ Cell phone _____

Employer _____ Work phone _____

Race_____ Ethnic Background Hispanic YES/NO Height _____Weight _____Education level_____

ALLERGIES Please list (medication, environmental, latex, etc):

_____

_____

OCCUPATION/HABITS

Current Occupation_____ Past Occupations (list most recent first):_____

If you have any exposures to substances or chemicals please specify: _____

_____

Do you smoke? : _____ Smoker for how long? _____ (years) Marijuana: ____Cigarette _____ Cigars_____

Smokeless tobacco _____ If no, have you smoked previously?_____

Caffeine usage: _____ Type _____ Average daily caffeine consumption _____

Alcohol use: _____ Type_____ Average weekly alcohol consumption _____

Current drugs or medications, including vitamins and nonprescription medications: Please List:

_____

_____

Do you exercise regularly? _____ Activity _____ Frequency_____

☐ Hot baths/saunas ☐ Other(specify) _____

☐ Bicycling (frequency _____

☐ Long distance driving _____

MARITAL AND SEX HISTORY:

Present marriage: Years _____ Sexual intercourse frequency: Per month _____ Erection: _____

Adequate penetration?_____ Ejaculation (normal or premature)_____

Difficulties_____

Pain or discomfort_____

Marital Problems _____

Previous marriage(s): ____Number of years ____Number of natural children _____Number of adopted children

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PAST INFERTILITY TREATMENT OR TESTING:

Please list tests performed, dates, results and name of physician: _____

_____

_____

OVER

MEDICAL HISTORY

Have you had any of the following illnesses? (Check box for yes)

Varicocele	☐	Fever (≥ 101 in past 3months)	☐	Prolonged fever	☐	Injuries	☐
Inguinal hernia	☐	Urogenital tuberculosis	☐	Syphilis	☐	Orchitis	☐
Kidney disease	☐	Undescended testicle	☐	Gonorrhea/chlamydia	☐	Epididymitis	☐
Urethritis	☐	Congenital disease, defect or mark	☐	Diabetes	☐	Prostatitis	☐
Hydrocele	☐	Mumps w/testicular involvement. Age	☐	Hypertension	☐		

Was your mother taking any medications or hormones during her pregnancy with you? _____

If you answered yes to any of the above questions please elaborate. Include dates of hospitalization, etc.:

_____

_____

_____

FAMILY HISTORY

Have there been any of the following diseases in your family?

Diabetes	☐	Down's syndrome	☐	Recurrent miscarriages	☐	Hypertension	☐
Heart disease	☐	Spina Bifida	☐	Children w/birth defects	☐	Schizophrenia or depressive psychosis	☐
Kidney disease	☐	Early deaths	☐	Deafness	☐	Infertility	☐
Tuberculosis	☐	Cleft lip or palate	☐	Mental retardation	☐	Other congenital anomalies	☐
Cancer	☐	Limb deformities	☐	Muscular dystrophy	☐		
Cystic fibrosis	☐	Blindness	☐	Sickle cell disease	☐		

If the answer to any of the above is yes, please elaborate: _____

_____

_____

Is there anything else you would like to add to what we have asked? _____

_____

_____