Name: ____________________ DOB: ___________ Today's Date: ___________ MR#: _______________

MALE MEDICAL HISTORY AND INFORMATION

Please fill out your Health History **fully**. YES!—We understand we ask for detailed personal information—having a thorough history helps us provide you with the BEST possible care!

Have you had any of the following?:

- Semen analysis? ☐ No ☐ Yes: Date:___________________ Result: ________________________________
- Pregnancy/child with another partner? ☐ No ☐ Yes: Dates:________________________ _____________
- Exposure to sexually transmitted diseases/infections (STDs/STIs)? ☐ No ☐ Yes:

  ☐ Chlamydia: date:_________ ☐ Syphilis: date:_________ ☐HIV/ AIDS: date:_________

  ☐ Gonorrhea: date:_________ ☐Hepatitis B: date:_________ ☐Hepatitis C: date:_________

  ☐ HPV/Genital warts: date:_________ ☐Herpes: ☐ Oral ☐ Genital: date:_________

  ☐ Mumps: date:_________
- Undescended testicles? ☐ No ☐ Yes: ☐ One side ☐ Both Surgery? (date):______________ __________
- Injury to your testicles? ☐ No ☐ Yes: Surgery? ☐ No ☐ Yes (date):________________________ _____
- Consult with a Urologist? ☐ No ☐ Yes(date):___________________
- Treatment with medication to improve sperm? ☐ No ☐ Yes: ☐ Clomid ☐ Femara

  ☐ hCG injections ☐ FSH injections
- Vasectomy? ☐ No ☐ Yes (date):____________ Vasectomy Reversal? ☐ No ☐ Yes (date):_____________
- Varicocele repair? ☐ No ☐ Yes (date):________________________ _____
- Prostate infections? ☐ No ☐ Yes (date):________________________ _____
- Exposure to excessive heat/chemicals? ☐ No ☐ Yes (date):________________________ _____
- Hot tub use? ☐ No ☐ Yes (date):________________________ _____
- Hernia repair? ☐ No ☐ Yes (date):________________________ _____
- Chemotherapy? ☐ No ☐ Yes (date):________________________ _____
- Family History of Infertility? ☐ No ☐ Yes (which family member):_____________________________
- Family History of Hereditary diseases? ☐ No ☐ Yes (details):______________________ _______
- Abnormal sense of smell? ☐ No ☐ Yes
- Difficulty with erections? ☐ No ☐ Yes
- Decreased libido/low sex drive? ☐ No ☐ Yes
  - How often do you and your partner have intercourse? ______ times per week/month (circle)

ALLERGIES ☐ No Known Drug Allergies

Medication	Allergic Reaction		Medication	Allergic Reaction

MEDICATIONS ☐ None (please include prescription, vitamin, herbal products, and over-the-counter meds)					
Name of Medication	Dose (mg/pill)	How many pills in:		Prescribing Doctor	Reason for taking Medication?
		Morning?	Evening?		

Please include medical problems and history of hospitalizations:

YOUR MEDICAL HISTORY Do **YOU** have a history of:	YES?	Age at diagnosis	Managing Physician	Comments
High Blood Pressure	☐			
Diabetes Type 1	☐			
Diabetes Type 2	☐			
Urinary infections	☐			
Prostatic infections	☐			
Multiple Sclerosis	☐			
Neurologic problems	☐			
Cancer	☐			
Trauma	☐			
Other:	☐			
Other:	☐			
Other:	☐			

PAST SURGERIES ☐ None		Reason for Surgery	Open procedure, Laparoscopic, or Robotic? Complications during or after surgery?
Year	Name or Type of Surgery		

Name: ____________________ DOB: ____________ Today's Date: ____________ MR#: ________________

SOCIAL HISTORY

SUBSTANCE USE			Year Quit
Tobacco—Smoking	☐ Never	________ packs/day x ________ years	
Tobacco—Chewing	☐ Never	________ cans/day x ________ years	
Alcohol	☐ Never	_________ drinks/_________ ☐ Beer ☐ Wine ☐ Liquor	
Illicit drugs	☐ Never	Which drugs?	

Notes:

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Patient's Signature: ___________________ ____________________________________ Date: ____________________

I confirm that I have reviewed the information above.

Provider's Signature: ____ Date: ____________________