MALE PATIENT INFORMATION

Houston Fertility Center
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PERSONAL INFORMATION

Name:_____ Date of Birth: _____

Spouse's Name: _____

GENERAL INFORMATION

Have you ever had a semen analysis? □ Yes □ No If yes, were the results normal? □ Yes □ No

Have you fathered any children? □ Yes □ No If yes, when? _____

Have you had any previous fertility treatment? □ Yes □ No

Have you had testicular or pelvic surgery? □ Yes □ No. If yes, specify date and type:

_____

Have you ever been treated for cancer? □ Yes □ No. If yes, specify date and type:

_____

Do you have any knowledge whether you have ever been exposed to any of the following drugs or toxins?

In Utero: □ Diethylstilbestrol; □ Antiandrogens.
Occupational Exposure: □ Carbon Disulfide; □ Lead; □ Estrogens; □ Cholordectone; □ Ethylene Glycol.
Prescriptions Drugs: □ Chemptherapuetic Agents; □ Sulfasalazine; □ Androgens.

PERSONAL HABITS

Check all that apply

□ Alcohol Use: How many glasses per week do you usually drink? _____
□ Do you smoke?____Daily____Occasionally____Rarely____Never. If yes,_____packs/day; If you did smoke but quit, when did you last smoke?____; how many pack/day?____for how many years?____.
□ Illicit or recreational drugs (Marijuana, Cocaine, Etc..)

MEDICATIONS

List ALL current medications or treatments (include vitamins, aspirin, antacids, laxatives, etc):

_____

Have you been tested for HIV?_____Yes No; If yes, Results _____

Allergies (medicines, food, pollens)?____Yes____No; if yes, list kind:

_____

Name_____

LIST ANY SIGNIFICANT FAMILY MEDICAL HISTORY

□ Self, your parents, siblings, children, aunts, uncles, grandparents, cousins_____

_____

CHECK THE APPROPRIATE SPACE FOR CONDITIONS OCCURING NOW OR IN THE PAST

[ ] HIV/AIDS	[ ] Sexual Problems	[ ] Testes injury
[ ] Diabetes	[ ] Herpes	[ ] Testes Infection
[ ] Hernia	[ ] Syphilis	[ ] Prostate Enlargement
[ ] High Blood Pressure	[ ] Gonorrhea	[ ] Prostatitis; Bacterial
[ ] Other:	[ ] Chlamydia	[ ] Measles: German