MALE PATIENT INFORMATION

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PERSONAL INFORMATION

Name: ___________________ DOB: __________ HT: _______ WT: __________

Address: ____

____

Home: ____________________; Work Phone: ____________________ Ethnic Origin: _________

SS#: ______________________; Married: Yes ____; No ____; Years: _________

Spouse's Name: ____

PERSONAL HABITS & GENERAL INFORMATION

Check all that apply

□ Alcohol Use: How many glasses per week do you usually drink? Wine ___ Beer ___ Cocktails ___.

□ 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..)

____

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:

____

HISTORY OF FERTILITY THERAPY (Check all that apply)

Which of the following tests have you had performed? Check all that apply and the results if known:

Test	When	Results
□ Semen Analysis	_______	________________
□ Chlamydia Test	_______	________________
□ Hormonal Assays FSH, LH Prolactin, Testosterone	_______	________________
□ Chromosome Test	_______	________________
□ Sperm Antibody Test	_______	________________
□ Testicular Biopsy	_______	________________
□ Thyroid Tests	_______	________________
□ X-Ray or ultrasound of Testes	_______	________________

□Other –
Specify____

Have you been treated for infertility before? □ Yes □ N
If yes, who was your physician? ____
What cause of infertility was diagnosed? ____
Treatment ____

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.

LIST ANY SIGNIFICANT FAMILY MEDICAL HISTORY

□ Self, your parents, siblings, children, aunts, uncles, grandparents, cousins__________________
____

MEDICATIONS

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

Medication	How Often	Reason
________________	_____________	____________________________
________________	_____________	____________________________
________________	_____________	____________________________
________________	_____________	____________________________

Usual Weight? _____________ # lbs recently lost or gained? ____________________________

Have you been tested for HIV? ____ Yes ____ No; If yes, Results _______________

Allergies (medicines, food, pollens)? ___ Yes ___ No; if yes, list kind:
____

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

[ ] HIV/AIDS
[ ] Allergies. List ______________
____
[ ] Anemia
[ ] Appendicitis
[ ] Arthritis
[ ] Bleeding or Bruising
[ ] Blood Clots
[ ] Blood Transfusion
[ ] Cancer Specify? ____________
____
[ ] Chlamydia
[ ] Chest Pain, Pressure
[ ] Colitis
[ ] Convulsions, Seizures
[ ] Diabetes
[ ] Diarrhea
[ ] Dizziness, Fainting
[ ] Excessive Sweating
[ ] Epilepsy
[ ] Gallbladder Problems
[ ] Gonorrhea
[ ] Goiter, Thyroid
[ ] Heart Trouble
[ ] Hernia
[ ] Hepatitis, Jaundice
[ ] Herpes
[ ] High Blood Pressure
[ ] Kidney Infection
[ ] Liver Problems
[ ] Lymph Node
[ ] Measles: German
[ ] Measles: Regular
[ ] Murmurs
[ ] Neurological Problems
[ ] Pneumonia
[ ] Prostate Enlargement
[ ] Prostatitis; Bacterial
[ ] Poor Appetite
[ ] Psychiatric disorders
[ ] Pains in Joints
[ ] Rheumatic fever
[ ] Seizures
[ ] Sexual Problems
[ ] Shortness of breath
[ ] Sore throats
[ ] Swollen Joints
[ ] Syphilis
[ ] Testes Infection
[ ] Testes injury
[ ] Testes injury
[ ] Tuberculosis
[ ] Ulcers
[ ] Urinating
[ ] Wheezing, Asthma
[ ] Other: