MALE FERTILITY HISTORY

Date:_________________________ Appointment Date:__________________

Name_________________________ Partner's Name____________________

Address ____

Telephone: Day ______________________ Eve. _____________________

Date of Birth_________________ Race____________________________

Duration of Relationship________________ Duration of Infertility ______________

WORK BACKGROUND

Brief description of present employment ______________________________

____

List past occupations (most current first) ______________________________

____

Have you ever been exposed to heat, chemicals, toxic fumes, or nuclear radiation during employment or military service? Circle all that apply. Other______________________

MEDICAL HISTORY

Height __________ Weight ___________ Blood Type ____________________

Have you gained or lost greater that 20 pounds in the past year? YES NO

Do you follow a special food diet? YES NO If yes, specify____________________

List the forms and frequency of regular exercise (swimming, cycling, running) and the age began

Exercise______________________________ Hrs/Wk________ Age________

Exercise______________________________ Hrs/Wk________ Age ________

Do you frequently take saunas or steam baths? YES NO

Do you do long distance driving? YES NO

Have you ever had surgery in the pelvic area? YES NO

If yes, specify what and when____

Have you ever received radiation or X-rays in the pelvic area? YES NO
If yes, specify ____

DO YOU HAVE OR HAVE YOU EVER HAD: (CIRCLE ALL THAT APPLY)

Appendicitis Arthritis Blood Transfusion Cancer Chlamydia Chronic Bronchitis

Diabetes Epilepsy Gonorrhea Heart Disease Hepatitis Herpes High Blood Pressure

Kidney Infection Migraines Measles: German/Regular Mumps with testes involved

Neurological Problems Inguinal Hernia Stomach/Bowel Problems Tuberculosis

Ulcers Pneumonia Prostatitis Psychiatric Disorder Rheumatic Fever Scarlet Fever

Seizures Syphilis Congenital Disease Testicular: Infection, Injury or Tumor Thyroid

Allergies ____

Current Medications ____

Have you had a high fever (over 102) beyond age 18? YES NO

DO YOU USE OR HAVE YOU EVER USED (CHECK ALL THAT APPLY)

_____ Alcohol – How many glasses per week to you usually drink?
Wine ___________________ Beer ___________________ Cocktails _______________

_____Cigarettes – Number of packs per day _____

_____Illicit or Recreational Drugs If you don’t feel comfortable writing this down, please discuss directly with your physician. Specify____

_____Caffeine Usage Items per day________________

SEXUAL HISTORY

Are you circumcised? YES NO

As a child, were both testes descended into the scrotum? YES NO

How many times have you been married? ____________

Have you ever tried to produce a child with another partner? YES NO

Have you ever produced a child with another partner? YES NO If yes, when?_________
If yes, how long did it take to produce a child?____

Do you have trouble getting an erection? YES NO
Maintaining an erection? YES NO

Do you have trouble with ejaculation? YES NO

Do you have discharge from the penis? YES NO

FAMILY HISTORY

Is there a family history of infertility? YES NO If yes, specify____________________

____

FAMILY MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

Diabetes Heart Disease Hypertension Kidney Disease Cancer Cystic Fibrosis

Sickle Cell Disease Early Deaths Down's Syndrome Spins Bifida Muscular Dystrophy

Cleft Lip/Palate Infertility Mental Retardation Recurrent Miscarriages

Other birth defects or congenital anomalies

FERTILITY TREATMENT HISTORY

Have you been treated for infertility before? YES NO
If yes, specify____

What cause of infertility was diagnosed?____

Have you ever had varicocele repair? YES NO If yes, when.________________________

Have you ever had vasectomy reversal or repair? YES NO If yes, when,_______________

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD PERFORMED?

_____Semen Analysis Date_______Results___________________
_____Blood Tests (FSH, LH, Testosterone) Date_______Results___________________
_____Thyroid Tests Date_______Results___________________
_____Testicular Ultrasound or X-ray Date_______Results___________________
_____Testicular Biopsy Date_______Results___________________
_____Antibody Test Date_______Results___________________
_____Chromosome Test Date_______Results___________________

Is your partner currently seeing a doctor for evaluation of infertility? YES NO
If yes, whom ____

Does the doctor feel that your partner has an infertility problem? YES NO
If yes, what is the diagnosis and is she being treated?_________________________________
____

Has you partner ever had children with another man? YES NO
If yes, when____

FEMALE FERTILITY HISTORY

Date_____________________ Appointment Date____________________

Name________________________ Partner's Name___________________

Address____

Telephone Day (______)________________ Eve.(______)_____________

Date of Birth____________________ Race_________________________

Duration of Relationship__________ Duration of Infertility_____________

Referring Doctor____

Nature of present employment (brief description)______________________

List past occupations (most current first)_____________________________

Are you exposed to chemicals or other substances in your work environment?____

MEDICAL HISTORY

Height___________ Weight___________ Blood Type (if known)________

Has your weight went up or down more than 20 pounds in the past year?___

Do you follow a particular diet?____________________________________

List the types and frequency of regular vigorous exercise (swim, cycle, run) and the age you began.

Exercise________________________Hrs/Wk___________Age__________

Exercise________________________Hrs/Wk___________Age__________

DO YOU HAVE OR EVER HAD (CIRCLE ALL THAT APPLY)

Anemia Appendectomy Blood Clots Diabetes Breast Discharge

Cancer Chlamydia Congenital Disease Endometriosis Gonorrhea

Stomach Issues Heart Disease Hepatitis Herpes Seizures

Hirsuitism(Dark Hair Growth) High Blood Pressure Kidney Infection

Ovarian Cysts Neurological Problems Migraines Psychiatric Issues

Pelvic Infection Syphilis Thyroid Problems Recurrent Vaginal Infections

Allergies____

Current Medications____

DO YOU OR HAVE YOU EVER USED (CHECK ALL THAT APPLY)

_____Alcohol – How many per week?
Wine____________ Beer____________ Cocktails_____________

_____Cigarettes – Number of packs per day______________________
How long have you smoked?__________________

_____Illicit or Recreational Drugs If you don't feel comfortable writing this down, please discuss directly with your physician. Specify__________
____

_____Caffeine Usage – Items per day_________________________________

MENSTRUAL AND PREGNANCY HISTORY

Age at first period?___________ First day of last period?________________

Are your periods regular? YES NO
If yes, how many days are between periods____________________

If no, how many times per year do you menstruate?____________

How many days does you period last?_______________________

Do you have cramps before, during or after your period?______________
Mild Moderate Severe
Medication used?_______________________________________

Do you bleed or spot between periods? YES NO
If yes, explain____

Is there anything else you want to tell us about your cycles?_____________
____

Last Pap Test Date_____________________ Normal Abnormal

Previous Mammogram YES NO Normal Abnormal

How many pregnancies (including abortions) have you had?___________

Year	Abortion	Miscarriage	Ectopic	Infertility Therapy to Conceive	How long to Conceive	Live Birth	Is current partner the father

Were there any complications during or after your pregnancies? YES NO
Explain____

Did your mother have any difficulty with conception or pregnancy?
YES NO Explain____

CONTRACEPTIVE AND SEXUAL HISTORY

Circle all forms of birth control that you have ever used and write the length of use. Pills_______ Ring_______ Patch_______ IUD_______
DepoProvera_______ Implanon_______ Tubal_______

How many times per week do you and your partner have intercourse?______

How many times do you have intercourse around ovulation?_____________

Is intercourse painful or difficult? YES NO

Do you use lubricants or intercourse? YES NO Specify______________

Circle all the disease history in you family.

Diabetes	Down's Syndrome	Hypertension
Heart Disease	Spina Bifida	Muscular Dystrophy
Kidney Disease	Cancer	Mental Retardation
Early Deaths	Infertility	Cystic Fibrosis
Cleft Lip/Palate	Sickle Cell Anemia	Recurrent Miscarriages

Other congenital anomalies or birth defects

HISTORY OF FERTILITY TREATMENT

Have you been treated for infertility before? YES NO
If yes, who was your physician_____________________________

What cause of infertility was diagnosed____________________________

What medications have you taken for infertility? Circle all that apply.
Clomiphene Citrate (Serophene, Clomid) HCG Estrogen
Progesterone Repronex Lupron GnRH Antibiotics

Have you ever had Intrauterine Insemination or In Vitro Fertilization?
YES NO If yes, using partner or donor sperm___________________

Which of the following tests have you had performed?

Postcoital Test Date_________ Results____________________

Thyroid Tests Date_________ Results____________________

Hormonal Tests Date_________ Results____________________
(FSH, LH, DHEA
Prolactin, Estrogen
Progesterone,

Testosterone)

Hysterosalpingogram Date__________ Results_____________________

Ultrasound Date__________ Results_____________________

Hysteroscopy Date__________ Results_____________________

Laparoscopy Date__________ Results_____________________

Have you ever had surgery for tubal reversal? YES NO
If yes, specify____

Have you ever had any other surgery (D&C, thyroid, appendectomy, ovarian, lysis of adhesions)? If yes, specify_____________________________
____

Have you ever had cervical cone biopsy, cryo or LEEP? YES NO
If yes, specify____

Is your partner seeing a doctor for evaluation of infertility? YES NO
If yes, who is the doctor____

Does the doctor feel your partner has a fertility problem? YES NO
If yes, diagnosis____

Has he ever fathered a child with another woman? YES NO
If yes, specify____