

Women's Clinic, Ltd.
Male History

Patient: _____ Age: _____ PCP / Referring Physician: _____

Name you would like us to use? _____ If married, which marriage is this for you? _____

Employer: _____ Job: _____ Work Phone: _____

Today's Date : _____

Please review the following questions. Give details for all positive responses.

Questions

Details of positive responses

- | | | |
|--|-----------------------------|---|
| Fathered any pregnancies in the past | <input type="checkbox"/> No | _____ |
| Infertility in previous relationships | <input type="checkbox"/> No | _____ |
| Semen analysis performed | <input type="checkbox"/> No | _____ |
| Normal analysis | <input type="checkbox"/> No | _____ |
| Decreased Count | <input type="checkbox"/> No | _____ |
| Decreased Motility | <input type="checkbox"/> No | _____ |
| Abnormal Forms | <input type="checkbox"/> No | _____ |
| Hormone studies performed | <input type="checkbox"/> No | _____ |
| Urology evaluation in the past | <input type="checkbox"/> No | _____ |
| Varicocele surgery | <input type="checkbox"/> No | _____ |
| Hormonal or antibiotic treatment | <input type="checkbox"/> No | _____ |
| Inseminations with your sperm | <input type="checkbox"/> No | _____ |
| Inseminations with donor sperm | <input type="checkbox"/> No | _____ |
| Previous sterilization | <input type="checkbox"/> No | _____ |
| Sterilization reversal | <input type="checkbox"/> No | _____ |
| Difficulty with erection / ejaculation | <input type="checkbox"/> No | _____ |
| Discomfort with ejaculation | <input type="checkbox"/> No | _____ |
| Decreased sex drive | <input type="checkbox"/> No | _____ |
| Sexually Transmitted Diseases | <input type="checkbox"/> No | {Gonorrhea, Chlamydia, Warts, Herpes, Urethritis, etc.} _____ |
| Hepatitis or HIV | <input type="checkbox"/> No | _____ |
| Exposure to STD / Hepatitis / HIV | <input type="checkbox"/> No | _____ |
| Prostrate problem / infection | <input type="checkbox"/> No | _____ |
| Mumps involving the testicles | <input type="checkbox"/> No | _____ |
| Significant injury to testicles | <input type="checkbox"/> No | _____ |
| Undescended testicles | <input type="checkbox"/> No | _____ |
| Failure of testicles to develop | <input type="checkbox"/> No | _____ |
| Previous pelvic surgery | <input type="checkbox"/> No | _____ |
| Head injury | <input type="checkbox"/> No | _____ |
| Diabetes or other hormone disorders | <input type="checkbox"/> No | _____ |
| DES exposure as a fetus | <input type="checkbox"/> No | _____ |
| Significant illness in last 5 years | <input type="checkbox"/> No | _____ |
| Fever over 101° in last 6 months | <input type="checkbox"/> No | _____ |
| Prolonged exposure to high heat | <input type="checkbox"/> No | _____ |
| Possible toxic exposures | <input type="checkbox"/> No | _____ |
| Cigarette smoking | <input type="checkbox"/> No | _____ |
| More than occasional alcohol intake | <input type="checkbox"/> No | _____ |
| Past / present recreational drug use | <input type="checkbox"/> No | _____ |
| Previous partner who used drugs | <input type="checkbox"/> No | _____ |

Is there a family history of any of the following?

Question

Details of positive response

Diseases known to be passed genetically to children

No

Infants born with birth defects

No

Mental retardation

No

Repeat miscarriages

No

Cystic Fibrosis

No

Tay Sachs

No

Sickle Cell Disease

No

Hormone disorders

No

Other

No

List current medications:

Physician notes: