

Advanced Reproductive Medicine and Surgery, P.C.

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**INFERTILITY HISTORY FORM**

**PART I: CONTACT INFORMATION**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Age \_\_\_\_\_

Date of Birth (MM/DD/YY) \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Indicate which number to call or leave messages:

Home Phone \_\_\_\_\_  Work Phone \_\_\_\_\_  Cell Phone \_\_\_\_\_

Are you married?  YES  NO  DIVORCED  OTHER \_\_\_\_\_

**Spouse/Male Partner's**

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Age \_\_\_\_\_

Not Applicable

Date of Birth (MM/DD/YY) \_\_\_\_\_ Occupation \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Indicate which number to call or leave messages:

Home Phone \_\_\_\_\_  Work Phone \_\_\_\_\_  Cell Phone \_\_\_\_\_

**Who referred you?**

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Former Patient/Friend \_\_\_\_\_

Website \_\_\_\_\_

Insurance (Name of Insurance) \_\_\_\_\_

**Who is your OB/GYN?**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Who is your Primary Care Physician?**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART II. FEMALE MEDICAL HISTORY AND INFORMATION**

Reason for Visit:  Infertility Evaluation  Sperm Insemination  Other \_\_\_\_\_

What are your expectations for this visit? \_\_\_\_\_

What questions do you want answered at this visit? \_\_\_\_\_

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a sperm sample, etc.?  YES  NO

How many months have you been having intercourse without using any form of birth control? \_\_\_\_\_

**Pregnancy Summary**

- Total Number of ALL Pregnancies: \_\_\_\_\_
- Number of Miscarriages (less than 20 weeks): \_\_\_\_\_
- Number of Ectopic/Tubal Pregnancies: \_\_\_\_\_
- Number of Elective Terminations (Abortions): \_\_\_\_\_
- Number of Full Term Deliveries: \_\_\_\_\_ Of these, how many were live births? \_\_\_\_\_ Stillborn? \_\_\_\_\_
- Number of Premature(less than 37 weeks) Deliveries: \_\_\_\_\_ Of these, how many were live births? \_\_\_\_\_ Stillborn? \_\_\_\_\_
- Any pregnancies with Birth Defects?  YES  NO Explain \_\_\_\_\_

Date Pregnancy Ended or Delivered	Months to Conception	Treatments Conceive	Delivery Type/D&C Complications	Current Partner?
1. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
2. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
3. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
4. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
5. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N
6. _____	_____	_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N

**Menstrual History**

- Menstrual cycle pattern (check all that apply):  Regular Periods  Irregular Periods  No Periods  
 Heavy Periods  Light Periods  Bleeding Between Periods  Spotting Before Periods
- Number of days between the start of one period to the start of the next period: \_\_\_\_\_ days
- How many days of bleeding do you have? \_\_\_\_\_ days
- Age when you had your first period: \_\_\_\_\_ years old
- Age when you first noticed: Breast development: \_\_\_\_\_ years old Pubic hair: \_\_\_\_\_ years old Underarm hair: \_\_\_\_\_ years old
- How many periods do you have per year? \_\_\_\_\_
- Do you need medication to bring on a period?  YES – what type? \_\_\_\_\_  NO
- If you do not have periods, at what age did you stop having them? \_\_\_\_\_ years old
- Do you have severe cramping or pelvic pain with your periods?  YES: \_\_Always \_\_Sometimes \_\_Recently  
 NO \_\_In the past

**Contraceptive History**

- None  Condoms – date of use \_\_\_\_\_  Diaphragm – dates of use \_\_\_\_\_  IUD – dates of use \_\_\_\_\_
- Birth control pills – dates of use \_\_\_\_\_ -complications? \_\_\_\_\_
- Never used birth control pills  Skin patch – dates of use \_\_\_\_\_ -complications? \_\_\_\_\_
- Injectable contraception (Depo-Provera®, Lunelle™, etc.) – date of use \_\_\_\_\_  Foam or Jelly
- Tubal sterilization procedure (tubes tied) –date (month/year) \_\_\_\_\_  Tubes untied –date \_\_\_\_\_
- Did your mother take DES when she was pregnant with you?  YES  NO  Don't Know

**Sexual History**

- How many times do you have intercourse per week? \_\_\_\_\_ times per week  None  Not applicable
- Have you used over-the-counter ovulation kits to time intercourse?  YES  NO
- Do you have pain with intercourse?  YES  NO
- Do you use lubricants (K-Y Jelly®, etc.) during intercourse?  YES-what types? \_\_\_\_\_  NO

Have you had any of the following sexually transmitted disease or pelvic infections?  YES  NO (check all that apply)

- Chlamydia-date \_\_\_\_\_  Gonorrhea-date \_\_\_\_\_  Herpes-date \_\_\_\_\_  Genital warts/HPV-date \_\_\_\_\_
- Syphilis-date \_\_\_\_\_  HIV/AIDS-date \_\_\_\_\_  Hepatitis-date \_\_\_\_\_  Other-date \_\_\_\_\_

**Pap smear History**

- When was your last Pap smear (MM/YY) \_\_\_\_\_  NORMAL  ABNORMAL
- When was your last abnormal Pap smear? \_\_\_\_\_  Not Applicable

Have you undergone any procedures as a result of an abnormal Pap smear?

- Yes (check all that apply)  No
- Colposcopy  Cryosurgery (Freezing)  Laser Treatment  Conization  LEEP procedure

**Breast Screening History**

Have you ever had a mammogram?  Yes-date \_\_\_\_\_  No

Result:  Normal  Abnormal-explain \_\_\_\_\_

Do you perform breast self-exams?  YES  NO

**Medical History**

• Are you allergic to any medications?  YES  NO (Please list and describe reactions) \_\_\_\_\_

• Are you allergic to any foods (peanuts, eggs, etc.)?  YES  NO (Please list and describe reactions) \_\_\_\_\_

• List any medications you are currently taking, including over-the-counter medicines: \_\_\_\_\_

• Do you take any herbal medicines/vitamins or health food supplements?  YES  NO (Please list) \_\_\_\_\_

• Do you have any medical problem(s)?  YES  NO (Please list type, dates, and treatments)

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_
- (4) \_\_\_\_\_
- (5) \_\_\_\_\_

• Did you have either of these childhood illnesses?  Chickenpox (Varicella)  German measles (Rubella)  Not Sure  
Other childhood diseases: \_\_\_\_\_

**Vaccinations**

- Chickenpox (Varicella)  Yes-date \_\_\_\_\_  No  Don't Know
- MMR-Measles, Mumps, and Rubella (German measles)  Yes-date \_\_\_\_\_  No  Don't Know
- BCG (Tuberculosis)  Yes-date \_\_\_\_\_  No  Don't Know
- Hepatitis B  Yes-date \_\_\_\_\_  No  Don't Know
- Polio  Yes-date \_\_\_\_\_  No  Don't Know
- Hepatitis A  Yes-date \_\_\_\_\_  No  Don't Know
- Tetanus  Yes-date \_\_\_\_\_  No  Don't Know
- Influenza  Yes-date \_\_\_\_\_  No  Don't Know

**Social History**

- Have you ever been sexually abused, molested, or raped?  YES  NO If yes, would you like to discuss it?  YES  NO
- How many caffeinated beverages (coffee, tea, soda) do you drink per day? \_\_\_\_\_  None
- Do you smoke cigarettes?  YES  NO How many/day? \_\_\_\_\_ How many years? \_\_\_\_\_  Quit-when \_\_\_\_\_
- Do you drink alcohol?  YES  NO  Beer # per week \_\_\_\_\_  Wine # per week \_\_\_\_\_  Liquor # per week \_\_\_\_\_
- Do you use marijuana, cocaine, or any other similar drug?  YES  NO Describe: \_\_\_\_\_
- Do you exercise?  YES  NO Describe: \_\_\_\_\_
- Are you aware of any radiation exposures other than x-rays?  YES  NO Describe: \_\_\_\_\_

**PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

• Have you had any surgeries?  YES  NO (List all surgeries in chronologic order.)  
 YEAR REASON AND TYPE OF SURGERY

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

• Did you have any anesthesia problems?  YES  NO Describe \_\_\_\_\_

**Physical Symptoms**

**General:**

- Recent weight gain or loss
- Anorexia / Bulimia
- Lack of energy
- Fever / Chills
- Other \_\_\_\_\_
- None

**Head, Eyes, Ears, Nose, and Throat:**

- Dizziness  Loss of sense of smell
- Headaches  Chronic nasal congestion
- Blurred vision  Ringing ears
- Hearing loss / deafness
- Other \_\_\_\_\_
- None

**Respiratory:**

- Shortness of breath
- Asthma  Bronchitis
- Pneumonia  Tuberculosis
- Bloody cough
- Other \_\_\_\_\_
- None

**Endocrine / Hormonal:**

- Diabetes  Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger / thirst
- Temperature intolerance  
hot flashes / or cold feeling
- Other \_\_\_\_\_
- None

**Breasts:**

- Discharge (clear? \_\_ bloody? \_\_ milky? \_\_)
- Lumps  Pain  Cancer
- Abnormal mammogram
- Reduction
- Augmentation / Breast implants  
(saline? \_\_\_\_\_ silicone? \_\_\_\_\_)
- Other \_\_\_\_\_
- None

**Neurological Problems:**

- Weakness / Loss of balance
- Seizures / Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other \_\_\_\_\_
- None

**Gastrointestinal:**

- Nausea / Vomiting  Ulcers
- Hepatitis  Diarrhea
- Blood in your stools  Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn's)
- Other \_\_\_\_\_
- None

**Genito-Urinary:**

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination  Leaking urine
- Blood in urine
- Herpes
- Other \_\_\_\_\_
- None

**Skin / Extremities:**

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other \_\_\_\_\_
- None

**Musculoskeletal:**

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other \_\_\_\_\_
- None

**Hematologic:**

- Blood clotting disorder/Blood clot
- Sickle Cell Anemia  Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons \_\_\_\_\_)
- Other \_\_\_\_\_
- None

**Cardiovascular:**

- Palpitations/Skipped beats
- Chest pain  Heart attack
- Stroke  Murmurs
- High blood pressure
- Rheumatic fever
- Other \_\_\_\_\_
- None

**Mental Health Problems:**

- Depression  Anxiety disorder
- Schizophrenia
- Other \_\_\_\_\_
- None

<p><b>PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)</b></p> <p>_____</p> <p>_____</p> <p>_____</p>
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**Family History:**

- |                        | <u>Living</u>                            | <u>Cause of Death / Age at Death</u> |
|------------------------|--|--------------------------------------|
| • Mother               | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |
| • Father               | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |
| • Brother(s)           | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |
|                        | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |
| • Sister(s)            | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |
|                        | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |
| • Maternal Grandmother | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |
| • Maternal Grandfather | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |
| • Paternal Grandmother | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |
| • Paternal Grandfather | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____    |

**Disorders In Your Family:**

**Relationship To You**

- |  | <u>YES</u>                                     | <u>NO</u>                | <u>DON'T KNOW</u>        |
|--|--|--------------------------|--------------------------|
| • Breast Cancer                            | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Ovarian Cancer                           | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Colon Cancer                             | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Other Cancer _____                       | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Diabetes                                 | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Thyroid problems                         | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Heart disease                            | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Blood clots                              | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Obesity                                  | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Psychiatric problems                     | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Tuberculosis                             | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Endometriosis                            | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Infertility                              | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Menopause before age 40                  | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Birth defects                            | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Cystic Fibrosis                          | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Tay-Sachs disease                        | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Canavan disease                          | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Bloom syndrome                           | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Gaucher disease                          | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Niemann-Pick disease                     | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Fanconi Anemia                           | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Familial Dysautonia                      | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Muscular Dystrophy                       | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Neurologic (brain/spine)                 | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Neural Tube Defects                      | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Bone/Skeletal Defects                    | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Dwarfism                                 | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Developmental delay                      | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Learning problems                        | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Polycystic kidney disease                | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Heart defect from birth                  | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Down syndrome                            | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Other chromosome defects                 | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Marfan syndrome                          | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Hemophilia                               | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Sickle Cell Anemia                       | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Thalassemia                              | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Galactosemia                             | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Deafness/Blindness                       | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Color Blindness                          | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Hemochromatosis                          | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> None of the above | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="checkbox"/> Other (specify _____) |                          |                          |

**What is your Ancestry?**

- African–American
- American Indian/  
Native American
- Ashkenazi Jewish
- Asian–American
- Cajun/French Canadian
- Caucasian
- Eastern European
- Hispanic/Caribbean
- Northern European
- Southern European
- Other  
(specify \_\_\_\_\_)

**Would you like to be screened for:**

- Cystic Fibrosis                       Y  N
- Sickle Cell Anemia                       Y  N
- Tay - Sachs disease                       Y  N
- Thalassemia                                       Y  N

- Have you had prior infertility testing or treatment elsewhere?  YES  NO

**Prior Tests** (check all that apply):  Basal body temperature chart (date \_\_\_\_\_ results \_\_\_\_\_)  
 Thyroid test (date \_\_\_\_\_ results \_\_\_\_\_)  Ovulation test kit (date \_\_\_\_\_ results \_\_\_\_\_)  
 Day 3 blood test for FSH level (date \_\_\_\_\_ results \_\_\_\_\_)  Hysterosalpingogram (HSG) (date \_\_\_\_\_ results \_\_\_\_\_)  
 Laparoscopy surgery (date \_\_\_\_\_ results \_\_\_\_\_)  Hysteroscopy surgery (date \_\_\_\_\_ results \_\_\_\_\_)  
 Progesterone blood test (date \_\_\_\_\_ results \_\_\_\_\_)  Prolactin blood test (date \_\_\_\_\_ results \_\_\_\_\_)

**Prior Treatment** (check all that apply):

<input type="checkbox"/> <u>Intrauterine insemination:</u>	# of cycles _____	Dates(mm/yy)(mm/yy) From _____ To _____	Outcome __Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant
<input type="checkbox"/> Clomiphene citrate with timed intercourse: maximum # tablets per day? _____	_____	From _____ To _____	__Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant
<input type="checkbox"/> Clomiphene citrate with insemination: maximum # tablets per day? _____	_____	From _____ To _____	__Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant
<input type="checkbox"/> Daily fertility drug injections with insemination maximum # vials per day? _____	_____	From _____ To _____	__Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant
<input type="checkbox"/> Completed in vitro fertilization cycle(s): 1. # eggs __ # embryos transferred __ # frozen __ 2. # eggs __ # embryos transferred __ # frozen __ 3. # eggs __ # embryos transferred __ # frozen __ 4. # eggs __ # embryos transferred __ # frozen __	_____	From _____ To _____ From _____ To _____ From _____ To _____ From _____ To _____	__Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant
<input type="checkbox"/> Frozen embryo transfers: 1. # embryos transferred _____ 2. # embryos transferred _____ 3. # embryos transferred _____ 4. # embryos transferred _____	_____	From _____ To _____ From _____ To _____ From _____ To _____ From _____ To _____	__Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant __Pregnant: __Delivered __Ectopic __Miscarriage __Not Pregnant
Canceled in vitro fertilization attempt(s): _____	_____		
<input type="checkbox"/> Any other prior treatment (describe): _____			

•Additional Information/Complications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Emotional Status**

- On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. \_\_\_\_\_
  - Do you see a counselor?  YES  NO For how long? \_\_\_\_\_ How often? \_\_\_\_\_
  - List any antidepressant/anti-anxiety medications you are currently taking. \_\_\_\_\_
  - Describe any emotional, marital, or sexual problems caused by your infertility. \_\_\_\_\_
- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)</b> _____ _____ _____ _____ _____ _____
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### PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by an urologist?  YES  NO
- Have you previously conceived with another woman?  YES How many times? \_\_\_\_  NO Birth Control used?  YES  NO
- Have you had a semen analysis?  YES  NO
- Do you have difficulty with erections?  YES  NO
- Do you have retrograde ejaculation of sperm into the bladder?  YES  NO
- Have you had any of the following sexually transmitted diseases or pelvic infections?  
 YES (check all that apply)  NO  
 Chlamydia - date \_\_\_\_\_  Gonorrhea - date \_\_\_\_\_  Herpes - date \_\_\_\_\_  Genital warts/HPV - date \_\_\_\_\_  
 Syphilis - date \_\_\_\_\_  HIV/AIDS - date \_\_\_\_\_  Hepatitis - date \_\_\_\_\_  Other \_\_\_\_\_ date \_\_\_\_\_
- Have you had a history of undescended testicles?  YES one side \_\_\_\_ both sides \_\_\_\_\_  NO
- Do you have scrotal or testicular pain?  YES  NO
- Did you have the mumps after puberty?  YES  NO
- Have you had prior injury to your testicles requiring hospitalization?  YES  NO
- Have you been diagnosed with any of the following diseases?  
 Diabetes Mellitus  YES  NO  Cancer  YES  NO  
 Multiple Sclerosis  YES  NO  Other neurologic problems  YES  NO  
 Prostatic infections  YES  NO  Urinary infections  YES  NO  
 High blood pressure  YES  NO If yes, any medications? \_\_\_\_\_
- Have you had any fever in the last 3 months?  YES  NO
- Have you had a vasectomy?  YES date \_\_\_\_\_  NO  
If yes, have you had a vasectomy reversal?  YES date \_\_\_\_\_  NO
- Have you had surgery for varicocele repair?  YES  NO
- Have you had hernia surgery?  YES  NO
- Did you undergo any bladder or penis surgery as a child?  YES  NO
- Are you exposed to prolonged heat in the workplace?  YES  NO
- Are you exposed to any radiation or harmful chemicals in the workplace?  YES  NO
- Have you had chemotherapy for cancer?  YES  NO
- Are you allergic to any medications?  YES  NO (Please list and describe reactions) \_\_\_\_\_

List your current medications: \_\_\_\_\_

List any current medical problem(s): \_\_\_\_\_

- How many caffeinated beverages do you drink per day? \_\_\_\_\_  None
- Do you smoke cigarettes?  YES  NO How many per day? \_\_\_\_ How many years? \_\_\_\_  Quit - when? \_\_\_\_\_
- Do you drink alcohol?  YES  NO  Beer -# per week? \_\_\_\_  Wine -# per week? \_\_\_\_  Liquor -# per week? \_\_\_\_
- Do you use marijuana, cocaine, or any other similar drug?  YES  NO (describe) \_\_\_\_\_
- Do you use herbal medicines/vitamins or health food store supplements?  YES  NO (describe) \_\_\_\_\_
- Are you aware of any radiation/toxic materials exposure?  YES  NO
- Do you use hot tubs regularly?  YES  NO
- Did your mother take DES during pregnancy to prevent miscarriage?  YES  NO  DON'T KNOW
- Have any of your immediate family members had difficulty conceiving a child?  YES  NO  
If yes, please describe \_\_\_\_\_

#### PHYSICIAN'S NOTES (FOR OFFICE USE ONLY)

\_\_\_\_\_  
\_\_\_\_\_

