

MALE PATIENT HISTORY

**I. IDENTIFYING INFORMATION**

Date \_\_\_\_\_  
 Name \_\_\_\_\_ Partner's Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone Number – Day: ( ) \_\_\_\_\_ Evening: ( ) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Partner's Date of Birth \_\_\_\_\_  
 Insurance Company \_\_\_\_\_

**II. TRAVEL//WORK AND GENERAL BACKGROUND**

All present employment – title(s), location, brief description, number of years employed:

Title	Location	Duties	Number Years
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Heat                                       Toxic Fumes                                       Other Specify \_\_\_\_\_  
 Chemicals                                       Nuclear Radiation

**III. MEDICAL HISTORY**

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type (if known) \_\_\_\_\_

	Yes	No
Have you lost greater than 20 pounds of weight in the last year? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Do you follow a particular food diet or have any special dietary habits? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:		
Exercise: _____ Hrs/Week _____ Age _____		
Exercise: _____ Hrs/Week _____ Age _____		
Do you frequently take saunas or steam baths? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery in the pelvic area? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____		
Have you ever received X-rays in the pelvic are for therapy or diagnosis? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain: _____		

Do you have or have you ever had (check all that apply):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Parasitic Infection       |
| <input type="checkbox"/> Appendicitis           | <input type="checkbox"/> Gallbladder Problems       | <input type="checkbox"/> Pneumonia                 |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Gonorrhea                  | <input type="checkbox"/> Prostatitis               |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Rheumatic Fever           |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Scarlet Fever             |
| <input type="checkbox"/> Breast Soreness        | <input type="checkbox"/> Herpes                     | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Breast Tenderness      | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Syphilis                  |
| <input type="checkbox"/> Cancer? _____          | <input type="checkbox"/> Kidney Infection           | <input type="checkbox"/> Testes Infection          |
| _____   | <input type="checkbox"/> Liver Problem              | <input type="checkbox"/> Testes Injury             |
| <input type="checkbox"/> Chlamydia              | <input type="checkbox"/> Loss of Balance            | <input type="checkbox"/> Testes Tumor              |
| <input type="checkbox"/> Chronic Bronchitis     | <input type="checkbox"/> Measles: German            | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Chronic Headaches      | <input type="checkbox"/> Measles: Regular           | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Colitis                | <input type="checkbox"/> Mumps                      | <input type="checkbox"/> Ulcers                    |
| <input type="checkbox"/> Cystic Fibrosis        | <input type="checkbox"/> Mumps with Testes Involved | <input type="checkbox"/> Visual Disturbances       |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Neurological Problems      | <input type="checkbox"/> Any Allergies? List _____ |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Nongonococcal Urethritis   | <input type="checkbox"/> _____                     |

	Yes	No
Have you ever been treated for cancer? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain therapy: _____		
Within the last year, have you taken any prescription medication? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list all prescriptions and problems for which you were taking them: _____		
_____		
Are you taking any over-the-counter medication on a regular basis? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list all medications and diagnoses: _____		
_____		
Have you had a high fever (over 102°F) during the past 3-4 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you use or have you ever used (check all that apply):		
<input type="checkbox"/> Alcohol – How many glasses per week do you usually drink? Wine ____ Beer ____ Cocktails _____		
<input type="checkbox"/> Cigarettes – Number of packs per day _____		
<input type="checkbox"/> Illicit or Recreational Drugs (Marijuana, Cocaine, etc) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____		
_____		

**IV. SEXUAL HISTORY**

	Yes	No
Are you circumcised? .....	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, were both testes descended into the scrotum? .....	<input type="checkbox"/>	<input type="checkbox"/>
At what age did you begin shaving regularly or start to grow a beard? .....	<input type="checkbox"/>	<input type="checkbox"/>
How many times have you been married? _____		
Have you ever produced a child with another partner? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how long did it take to produce a child? _____ When was this (dates)? _____		
Have you ever <i>tried</i> produced a child with another partner? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble getting an erection? .....	<input type="checkbox"/>	<input type="checkbox"/>
Maintaining an erection? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble with ejaculations? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, €Premature ejaculations €Retrograde ejaculations?		
Do you feel that some of your ejaculate is deposited in the vagina? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have orgasms without ejaculation during masturbation? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have discharge from the penis? .....	<input type="checkbox"/>	<input type="checkbox"/>
How many times per week do you and your partner now have intercourse? .....	<input type="checkbox"/>	<input type="checkbox"/>
How many times do you have intercourse around ovulation? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed a change in your sexual drive recently? .....	<input type="checkbox"/>	<input type="checkbox"/>

**V. FAMILY HISTORY**

	Yes	No
Is there a family history of infertility? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who (list all members and relationship to you): _____		
_____		
Is there a history of hormonal disorders in your family? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who (relationship to you) and what type: _____		
_____		

**VI. HISTORY OF FERTILITY THERAPY**

Have you been treated for infertility before? .....  **Yes**  **No**  
 If yes, who was your physician? \_\_\_\_\_  
 What cause of infertility was diagnosed? \_\_\_\_\_

What drugs have you taken for infertility? Check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> clomiphene citrae (Serophene <sup>®</sup> Clomid <sup>®</sup> ) | <input type="checkbox"/> hCG (Profasi <sup>®</sup> , A.P.L <sup>®</sup> ) |
| <input type="checkbox"/> hMG (Pergonal <sup>®</sup> , Menopur <sup>®</sup> )             | <input type="checkbox"/> fluoxymesterone (Halotestin <sup>®</sup> )       |
| <input type="checkbox"/> tamoxifen   | <input type="checkbox"/> GnRH or LHRH (Factrel <sup>®</sup> )             |
| <input type="checkbox"/> testolactone  | <input type="checkbox"/> urofollitropin or FSH (Metrodin <sup>®</sup> )   |
| <input type="checkbox"/> bromocriptine (Parlodel <sup>®</sup> )                          | <input type="checkbox"/> Other – Specify _____                            |
| <input type="checkbox"/> testosterone or Male Hormone                                    | <input type="checkbox"/> None   |

Have you ever had varicocele repair? .....	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
If yes, when? _____		
Have you ever had vasectomy reversal or repair? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when? _____		
Have you and your partner ever tried artificial insemination? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, using <input type="checkbox"/> your sperm? <input type="checkbox"/> donor sperm?		
Have you and your partner ever tried in vitro fertilization? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when and explain: _____		

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

- |  |             |                |
|--|-------------|----------------|
| <input type="checkbox"/> Semen Analysis                                    | When? _____ | Results: _____ |
| <input type="checkbox"/> Chlamydia Test                                    | When? _____ | Results: _____ |
| <input type="checkbox"/> Mycoplasma Test                                   | When? _____ | Results: _____ |
| <input type="checkbox"/> Antibody Test                                     | When? _____ | Results: _____ |
| <input type="checkbox"/> Hamster Egg Test                                  | When? _____ | Results: _____ |
| <input type="checkbox"/> Chromosome Test                                   | When? _____ | Results: _____ |
| <input type="checkbox"/> Testicular Biopsy                                 | When? _____ | Results: _____ |
| <input type="checkbox"/> X-Ray or Ultrasound of Testes                     | When? _____ | Results: _____ |
| <input type="checkbox"/> Hormonal Tests (FSH, LH, prolactin, testosterone) | When? _____ | Results: _____ |
| <input type="checkbox"/> Thyroid Tests                                     | When? _____ | Results: _____ |
| <input type="checkbox"/> Other – Specify _____                             | When? _____ | Results: _____ |

Is your partner currently seeing a doctor for evaluation of infertility? .....	<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>
If yes, specify physician name and location: _____		
Does the doctor feel that your partner has an infertility problem? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what is the diagnosis and how is she being treated? _____		
_____		
Has she ever had children with another man? .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when? _____		

**Sujatha Gunnala, MD**  
3125 North 32<sup>nd</sup> Street Suite 200  
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Phone: (602) 956-7481

**Southwest Fertility Center**  
Initial Visit  
Male Questionnaire

**Linda Nelson, MD, PhD**  
1520 S Dobson Rd Suite 215  
Mesa, AZ 85202  
Fax: (602) 956-7591

**FOR PHYSICIAN USE ONLY**

**VII. PHYSICAL FINDINGS**

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**VIII. SURGERY**

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**IX. OTHER COMMENTS**

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**X. COURSE OF ACTION**

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