



FERTILITY CENTER OF THE CAROLINAS

MALE PATIENT HISTORY: INFERTILITY

I. Identifying Information

Date: _____
 Name: _____ Partner's Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone Number: Day (_____) _____ Evening (_____) _____

Referring Physician: Name _____
 Address _____

Age: _____ Date of Birth: _____ Partner's Age: _____ Date of Birth: _____

II. Fertility History

How long have you and your present partner been trying to conceive: _____
 Have you ever been infertile with a past partner: _____ If so, how long: _____
 Have you ever fathered a pregnancy before: YES NO
 Have you had any of the following tests performed: (Check all that apply and the results)

	Date	Results
<input type="checkbox"/> Semen Analysis	_____	_____
<input type="checkbox"/> Antisperm Antibodies	_____	_____
<input type="checkbox"/> Gonorrhea/Chlamydia Cultures	_____	_____
<input type="checkbox"/> Hormone Tests	_____	_____
<input type="checkbox"/> Urological Exam	_____	_____

III. Medical History

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal Puberty | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rubella (German Measles) |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> HIV | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision Problems |

Are you allergic to any medications: _____ If so, what: _____
Have you ever had surgery: _____ Date and Type: _____
Have you ever had an injury to your genitals: _____ Specify: _____
Have you ever had any of the following: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Exposure to Radiation |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Prolonged Exposure to Chemicals |
| <input type="checkbox"/> Veneral Warts | <input type="checkbox"/> Prostatitis | |

III. Social History

Current or Recent Employer/Position: _____
Do you drink alcohol: _____ Number of drinks per week: _____
Do you smoke: _____ Number of cigarettes per day: _____ Number of years smoking: _____
Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.): _____
Please specify: _____
Do you have an exercise program: _____ Type: _____ Number of hours per week: _____
Are you on a special diet: _____ Type: _____

V. Review of Systems

What is your height: _____ Current weight: _____ Ideal weight: _____
Have you had more than a 10 pound weight gain/loss this past year: Yes No
If so, how much: _____ Was this intentional: Yes No
What is your blood type (if known): _____

VI. Family History

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you: Yes No

Do any family members have significant health problems or inherited diseases: Yes No

Check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Brain/Spinal Defects | <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tay-Sachs Disease |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |

Who: _____

VII. Additional Health Information

