



AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE Infertility History Form

FOR OFFICE USE ONLY

IMPORTANT:

**Please complete this form and
bring it with you to your scheduled visit.**

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertility history. It consists of three parts:

- Part I: Contact information
- Part II: Your medical history
- Part III: Your spouse/male partner's medical history (if applicable)

PART I: CONTACT INFORMATION

First Name _____ Middle Initial ____ Last Name _____ Age _____

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 Telephone () _____ Work Telephone () _____ Cell Phone () _____

Are you married? Yes No Divorced Other _____

Spouse/Partner's First Name _____ Middle Initial ____ 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 Telephone () _____ Work Telephone () _____ 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 Notes
(for office use only)**

Blank area for physician notes with horizontal lines.

PART II: FEMALE MEDICAL HISTORY AND INFORMATION

Reason for Visit: Infertility Evaluation 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 semen 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? ____ How many were stillborn? ____
- Number of Premature (less than 37 weeks) Deliveries: _____ Of these, how many were live births? ____ How many were stillborn? ____
- Any Pregnancies with Birth Defects? Yes - explain _____ No

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to 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 Spotting before periods No periods
 Heavy periods Light periods Bleeding between periods
- Number of days between the start of one period the start of the next period: _____ days
- How many days of bleeding do you have? _____ days
- Dates of the 1st day of your last 2 menstrual periods: ____/____/____; ____/____/____
- 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 __ In the past No
- Did your mother take DES (an estrogen derivative) when she was pregnant with you? Yes No Don't know

Contraceptive History

- None Condoms - dates of use _____ Diaphragm - dates of use _____ Foam or Jelly
- Birth control pills - dates of use _____ - complications? _____ Never used birth control pills
- Injectable contraception (Depo-Provera®, Lunelle™, etc.) - dates of use _____ - complications? _____
- Skin patch - dates of use _____ - complications? _____ IUD - dates of use _____
- Tubal sterilization procedure (tubes tied) - date (month/year) ____/____ Tubes untied - date (month/year) ____/____

Sexual History

- Are you sexually active? Yes No Is your partner Male Female
- 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®, Astroglide® etc.) during intercourse? Yes - what types? _____ 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 _____

Pap Smear History

- When was your last pap smear (month and year)? ____/____/____ 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 ____ Result: normal abnormal - explain _____ No
- Do you perform breast self exams? Yes No

Medical History

- Are you allergic to any medications? Yes No
If yes, please list and describe reactions: _____

- Are you allergic to any foods (peanuts, eggs, etc.)? Yes No
If yes, 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 store supplements? Yes No
If yes, please list : _____

- Do you have any medical problem(s)? Yes (Please list type, dates, and treatments.) No
- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____

Surgical History

- Have you had any surgeries? Yes (List all surgeries in chronologic order.) No

Year	Reason and Type of Surgery
(1) _____	(1) _____
(2) _____	(2) _____
(3) _____	(3) _____
(4) _____	(4) _____
(5) _____	(5) _____
(6) _____	(6) _____
(7) _____	(7) _____

- Did you have any problems with anesthesia? Yes (describe _____) No
- Have you had either of these childhood illnesses? Chickenpox (Varicella) German Measles (Rubella) Don't know
Other childhood diseases: _____

Vaccinations

- BCG (Tuberculosis): Yes (dates _____) No Don't know
- Chickenpox (Varicella): Yes (dates _____) No Don't know
- Hepatitis A: Yes (dates _____) No Don't know
- Hepatitis B: Yes (dates _____) No Don't know
- Influenza: Yes (dates _____) No Don't know
- MMR - Measles, Mumps, and Rubella (German Measles): Yes (dates _____) No Don't know
- Pertussis (Tdap_) Yes (dates _____) No Don't know
- Polio: Yes (dates _____) No Don't know
- Tetanus: Yes (dates _____) No Don't know

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ None
- Do you smoke cigarettes? Yes How many/day? _____ How many years? _____ Quit - when? _____ No
- Do you drink alcohol? Yes How many drinks per week? _____
- Have you casually used marijuana, cocaine, or any other similar drug? Yes (describe _____) No
- Do you exercise? Yes (describe _____) No
- Are you aware of any radiation exposures other than X-rays? Yes (describe _____) No
- Do you feel safe in your own home? Yes (describe _____) No

Review of Physical Symptoms

General:

- Recent weight gain or loss
- Anorexia/ ulimia
- Lack of energy
- Fever/Chills
- Other _____
- None

Endocrine/Hormonal:

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

Gastrointestinal:

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

Musculoskeletal:

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

Mental Health Problems:

- Depression Anxiety disorder
- Schizophrenia
- 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

Breasts:

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

Genito-Urinary:

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination Leaking urine
- Blood in the urine
- Herpes
- Other _____
- None

Hematologic:

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

Respiratory:

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

Neurological Problems:

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

Skin/Extremities:

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

Cardiovascular:

- Palpitations/ kipped beats
- Chest pain Heart attack
- Stroke Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse (Need antibiotics before dental procedures? Yes ___ No ___)
- Other _____
- None

Physician Notes (for office use only) _____

Family History

	Living	Cause of Death/Age at Death
• 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	_____
• Sister(s)	<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	_____

Medical or Genetic Disorders in You/Your Family

	Self or Relationship to You		
• Baby with birth defect	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Birth defects	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Blood clots	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Bloom syndrome	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Bone/Skeletal Defects	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Canavan disease	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Cancer	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Breast cancer	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Colon cancer	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Ovarian cancer	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Other cancer _____	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Color Blindness	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Cystic Fibrosis	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Deafness/Blindness	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Developmental delay	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Diabetes	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Down syndrome	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Other chromosome defects	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Dwarfism	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Endometriosis	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Epilepsy/Seizure disorder	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Familial dysautonomia	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Fanconi Anemia	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Fragile X	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Galactosemia	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Gallstones	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Gaucher disease	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Glaucoma	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Heart defect from birth	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Heart disease	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Hemochromatosis	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Hemophilia	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Hepatitis	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• High blood pressure	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• High cholesterol	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Hormonal disorder	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Huntington Chorea	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Hydrocephalus	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Infertility	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Inherited disorder	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Learning problems	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Marfan syndrome	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Menopause before age 40	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Miscarriages (2 or more)	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Muscular dystrophy	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Myotonic dystrophy	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Neural tube defects	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Neurofibromatosis	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
• Neurologic (brain/spine)	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No	<input type="checkbox"/> Don't Know	

What is your Ancestry?

- American Indian or Alaskan Native
- Asian
- Hawaiian Native or other Pacific Islander
- Black, not of Hispanic Origin
- Hispanic
- White, not of Hispanic Origin
- Mixed race
- Other (specify _____)

- Niemann-Pick disease Yes _____ No Don't Know
- Obesity Yes _____ No Don't Know
- Polycystic kidney disease Yes _____ No Don't Know
- Psychiatric problems Yes _____ No Don't Know
- Renal disease Yes _____ No Don't Know
- Sickle cell anemia Yes _____ No Don't Know
- Spinal muscular atrophy (SMA) Yes _____ No Don't Know
- Tay-Sachs disease Yes _____ No Don't Know
- Thalassemia Yes _____ No Don't Know
- Thyroid problems Yes _____ No Don't Know
- Tuberculosis Yes _____ No Don't Know

None of the above Other (Specify _____)

GENETIC SCREENING

It is recommended that all couples attempting conception be offered cystic fibrosis screening. Cystic fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies depend on your ethnic background.

You may be offered additional screening based on your ethnicity. Are you:

African American Yes No Ashkenazi Jewish Yes No Mediterranean/Asian/French Canadian Yes No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

PRIOR INFERTILITY TESTING AND TREATMENT

• 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):

	# of cycles	Dates (mo/yr) (mo/yr)	Outcome
<input type="checkbox"/> Intrauterine insemination:	_____	From ___/___ to ___/___	__ 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 ___	_____	____/____	__ Pregnant: __ Delivered __ Ectopic __ Miscarriage; __ Not Pregnant
2. # eggs ___ #embryos transferred ___ #frozen ___	_____	____/____	__ Pregnant: __ Delivered __ Ectopic __ Miscarriage; __ Not Pregnant
3. # eggs ___ #embryos transferred ___ #frozen ___	_____	____/____	__ Pregnant: __ Delivered __ Ectopic __ Miscarriage; __ Not Pregnant
4. # eggs ___ #embryos transferred ___ #frozen ___	_____	____/____	__ Pregnant: __ Delivered __ Ectopic __ Miscarriage; __ Not Pregnant
<input type="checkbox"/> Frozen embryo transfers:			
1. # embryos transferred _____	_____	____/____	__ Pregnant: __ Delivered __ Ectopic __ Miscarriage; __ Not Pregnant
2. # embryos transferred _____	_____	____/____	__ Pregnant: __ Delivered __ Ectopic __ Miscarriage; __ Not Pregnant
3. # embryos transferred _____	_____	____/____	__ Pregnant: __ Delivered __ Ectopic __ Miscarriage; __ Not Pregnant
4. # embryos transferred _____	_____	____/____	__ Pregnant: __ Delivered __ Ectopic __ Miscarriage; __ Not Pregnant
<input type="checkbox"/> 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 - For how long? _____ How often? _____ No
- List any antidepressant/antianxiety medications you are currently taking. _____
- Describe any emotional, marital, or sexual problems caused by your infertility. _____

PATIENT'S SIGNATURE _____	DATE _____
I confirm that I have reviewed the information above.	
PHYSICIAN'S SIGNATURE _____	DATE _____

PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by a urologist? Yes No
- Have you previously conceived with another woman? Yes: How many times? _____ No: Birth control used?
- Have you had a semen analysis? Yes No

	Date	Volume	Count	Motility	Morphology
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

- Do you have difficulty with erections? Yes No
- Are you able to ejaculate inside your partner's vagina? 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 severe testicular pain?
 Yes (check all that apply) No
 - Chlamydia - date _____ Gonorrhea - date _____ Herpes - date _____ Genital warts/HPV - date _____
 - Syphilis - date _____ HIV/AIDS - date _____ Hepatitis - date _____ Other _____
- Have you had a history of undescended testicles? Yes - One side ___ Both ___ No
- Have you ever had torsion/twisting of the testicles? Yes No
- Did you have mumps after puberty? Yes No
- Have you had injury to your testicles requiring an ER visit or hospitalization? Yes No
- Have you been diagnosed with any of the following diseases?
 - Diabetes mellitus Cancer
 - Multiple Sclerosis Other neurologic problems - _____
 - Prostatic infections Urinary infections - _____
 - High Blood Pressure - If yes, any medications? _____
- Have you had fever (>101° F) 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 varicocele surgery? Yes No
- Have you had hernia surgery? Yes No
- Have you had other surgery to the scrotum or groin area? 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 or radiation for cancer? Yes No

- Are you allergic to any medications? Yes No

If yes, 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 How many/day? _____ How many years? _____ Quit - when? _____ No
- Do you drink alcohol? Yes No
If yes, how many drinks per week? _____
- Have you casually used marijuana, cocaine, or any other similar drug? Yes (describe _____) No
- Do you use herbal medicines/vitamins or health food store supplements? Yes (describe _____) No
- Are you aware of any solvents/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 _____

Family History

	Living	Cause of Death/Age at Death
• 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	_____
• Sister(s)	<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	_____

What is your Ancestry?

American Indian or Alaskan Native

Asian

Haor Pacific Islander

Black, not of Hispanic Origin

Hispanic

White, not of Hispanic Origin

Other (specify _____)

Disorders in Your Family

	Relationship to You		
• Bloom syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Bone/Skeletal Defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Canavan disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Color Blindness	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Cystic Fibrosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Deafness/Blindness	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Developmental delay	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Down syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Other chromosome defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Dwarfism	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Familial Dysautonia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Fanconi Anemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Galactosemia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Gaucher disease	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Heart defect from birth	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Hemochromatosis	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Hemophilia	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Learning problems	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Marfan syndrome	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Muscular Dystrophy	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Neural Tube Defects	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
• Neurologic (brain/spine)	<input type="checkbox"/> Yes _____	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know

- Niemann-Pick disease Yes _____ No Don't Know
- Polycystic kidney disease Yes _____ No Don't Know
- Sickle Cell Anemia Yes _____ No Don't Know
- Tay-Sachs disease Yes _____ No Don't Know
- Thalassemia Yes _____ No Don't Know
- High blood pressure Yes _____ No Don't Know
- Glaucoma Yes _____ No Don't Know
- High cholesterol Yes _____ No Don't Know
- Gallstones Yes _____ No Don't Know
- Hepatitis Yes _____ No Don't Know
- None of the above Other (Specify _____)

SPOUSE/MALE PARTNER'S SIGNATURE _____ **DATE** _____

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE _____ **DATE** _____