STILLWATER
MEDICAL GROUP
A member of Lakeview Health
Women's Center

Infertility Male History Form

Complete the form to the best of your knowledge.

I. IDENTIFYING INFORMATION Date_____

Name_____ Partner's Name_____

Date of Birth_____ Nature of present employment_____

II. MEDICAL HISTORY Height _____ Weight_____

Do you have or have you ever been diagnosed with or treated for (check all that apply)

____Neurological Problems	____Asthma	____Breast Discharge
____Poor Sense of Smell	____Tuberculosis	____Chlamydia
____Seizures	____Gonorrhea	____Visual Disturbance
____Kidney Infection	____Herpes	____Mumps
____Mumps/Testes Involvement	____Anemia	____Colitis
____Prostatitis	____Cancer Specify:_____	
____Diabetes	____Syphilis	____Gall Bladder
____HIV/AIDS	____Disease/Surgery	____Testes Infection
____Heart Disease	____Hepatitis	____Testes Injury
____High Blood Pressure	____Liver problems	____Testes Tumor
____Thyroid Disease	____Undescended Testes	

ALLERGIES

General Allergies Yes No If yes, list_____

Drug Allergies Yes No If yes , list_____

PRESCRIBED MEDICATIONS

Past Year Yes No If yes, list_____

Current Yes No If yes, list_____

OVER THE COUNTER MEDICATIONS

Current Yes No If yes, list_____

Homeopathic/Herbal Yes No If yes, list_____

CURRENT USE OF THE FOLLOWING

Alcohol Yes No If yes, type:_____ amount per week:_____

Smoking Yes No If yes, number of cigarettes per day:_____

Recreational Drugs Yes No If yes ,type:_____ frequency:_____

Do you frequently use saunas, steam baths, or whirlpools? Yes No
Have you had a high fever (over 102° F) during the past three to four months? Yes No

III. SEXUAL HISTORY

Have you ever tried to produce a child with another partner? Yes No
Have you produced a child with another partner? Yes No
If yes, how long did it take to produce the child?_____
When?_____
Do you have trouble getting an erection? Yes No
Do you have trouble maintaining an erection? Yes No
Do you have trouble with ejaculations? Yes No
If yes, ____Premature ejaculations ____Retrograde ejaculations
Do you feel that your ejaculate is deposited into the vagina? Yes No
Do you have any abnormal discharge from your penis? Yes No
How many times per week do you and your partner have intercourse?_____
How many times do you have intercourse around ovulation?_____
Have you recently noticed a change in your sexual drive? Yes No
Have you had an injury or abnormality to your penis, testicles or prostate? Yes No
If yes, when? _____
Outcome/result_____
Indicate your sexual orientation by circling one of the following:
Heterosexual Homosexual Bisexual
Has your partner ever conceived a child with someone other than yourself? Yes No

IV. FAMILY HISTORY

Is there a history of hormonal disorders in your family? Yes No
If yes, who and what type?_____

Is there a family history of

Cystic Fibrosis Yes No If yes, whom:_____
Tay Sachs Disease Yes No If yes, whom:_____
Sickle Cell Anemia Yes No If yes, whom:_____

With which of the following racial/ethnic group do you identify? Check the appropriate racial/ethnic group.
____American Indian/ Alaska Native ____Asian ____White/Caucasian ____Hispanic/Latino

____ Black/African American ____Native Hawaiian/Other Pacific Islander ____Unknown

V. INFERTILITY HISTORY/TREATMENT

Have you ever been treated for infertility before? Yes No
If yes, who was your physician?_____
What cause of infertility was diagnosed?_____
Is your partner currently seeing a doctor for evaluation of infertility? Yes No
If yes, specify physician name and location._____

Which of the following tests have you had performed? Check all that apply and results.
____Semen Analysis When?_____ Results:_____
When?_____ Results:_____
When?_____ Results:_____

____Chlamydia Test When?_____ Results:_____
____Mycoplasma Test When?_____ Results:_____
____Antisperm Antibody Test When?_____ Results:_____
____Hamster Egg Penetration Assay When?_____ Results:_____
____Chromosome Test When?_____ Results:_____
____Testicular Biopsy When?_____ Results:_____
____X-ray or Ultrasound of Testes When?_____ Results:_____
____Hormonal Assays
(FSH, LH, Prolactin Testosterone) When?_____ Results:_____
____Thyroid Tests When?_____ Results:_____
____Other- Specify:_____ When?_____ Results:_____

Have you ever had any of the following procedures or surgeries?

Hernia Repair	Yes	No	Date:_____
Varicocele Repair	Yes	No	Date:_____
Vasectomy	Yes	No	Date:_____
Vasectomy Reversal	Yes	No	Date:_____
Other:_____	Yes	No	Date:_____

What drugs have you taken for infertility? Check all that apply.
____Clomiphene Citrate (Serophene®, Clomid®) ____hCG(Profasi®, A.P.L.®) ____hMG(Pergonal®)
____Urofollitropin or FSH (Metrodin®) ____Bromocriptine(Parlodel®)
____Testosterone or Male Hormone ____Other- Specify_____