

**REPRODUCTIVE HEALTH CENTER  
MALE PATIENT HISTORY**

**I. IDENTIFYING INFORMATION**

Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name\_\_\_\_\_ Partner's Name\_\_\_\_\_

Address\_\_\_\_\_

Telephone Number - Day:( )\_\_\_\_\_

Evening:( )\_\_\_\_\_

Date of Birth\_\_\_\_\_ Partner's Date of Birth\_\_\_\_\_ Duration of Relationship\_\_\_\_\_

Duration of Infertility, if present\_\_\_\_\_

Insurance Company\_\_\_\_\_ Insurance I.D.#\_\_\_\_\_

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

All present employment -

title(s), location, brief description, number of years employed:

1.\_\_\_\_\_

2.\_\_\_\_\_

3.\_\_\_\_\_

Are you or have you ever been exposed to any of the following during employment or military service:

Excessive Heat

Chemicals

Toxic Fumes

Nuclear Radiation

Other Specify:\_\_\_\_\_



Has she ever had children with another man? yes no

If yes, when? \_\_\_\_\_

Do you have any allergies to any medications? yes no

If yes, what reactions do you have? Please list.

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Have you ever received X-rays in the pelvic area  
for therapy or diagnosis? yes no

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"/> Anorexia                  | <input type="checkbox"/> Gallbladder Problems              | <input type="checkbox"/> Pelvic Infection                   |
| <input type="checkbox"/> Appendicitis              | <input type="checkbox"/> Gonorrhoea                        | <input type="checkbox"/> Pneumonia                          |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Heart Disease                     | <input type="checkbox"/> Poor Sense of Smell                |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Hepatitis Type?                   | <input type="checkbox"/> Problems with Skin<br>Pigmentation |
| <input type="checkbox"/> Bladder Infections        | <input type="checkbox"/> Herpes                            | <input type="checkbox"/> Rheumatic Fever                    |
| <input type="checkbox"/> Blood Transfusions        | <input type="checkbox"/> Hirsutism (Excess Hair<br>Growth) | <input type="checkbox"/> Scarlet Fever                      |
| <input type="checkbox"/> Breast Milky Discharge    | <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Seizures                           |
| <input type="checkbox"/> Breast Soreness           | <input type="checkbox"/> Immunization: German<br>Measle    | <input type="checkbox"/> Spastic Colon                      |
| <input type="checkbox"/> Breast Tenderness         | <input type="checkbox"/> Kidney Infection                  | <input type="checkbox"/> Syphilis                           |
| <input type="checkbox"/> Cancer?<br>Specify: _____ | <input type="checkbox"/> Liver Problems                    | <input type="checkbox"/> Thyroid Problems?<br>Type? _____   |
| <input type="checkbox"/> Chest Pain                | <input type="checkbox"/> Loss of Balance                   | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Chlamydia                 | <input type="checkbox"/> Lupus                             | <input type="checkbox"/> Ulcers                             |
| <input type="checkbox"/> Chronic Bronchitis        | <input type="checkbox"/> Measles: German                   | Vaginitis: Trichomoniasis                                   |
| <input type="checkbox"/> Chronic Headaches         | <input type="checkbox"/> Measles: Regular                  | Yeast, # of episodes:<br>_____                              |
| <input type="checkbox"/> Colitis                   | <input type="checkbox"/> Neurological Problems             | <input type="checkbox"/> Visual Disturbances                |
| <input type="checkbox"/> Color Blind               | <input type="checkbox"/> Nongonococcal Urethritis          | <input type="checkbox"/> Vitiligo                           |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Ovarian Cysts                     |   |
| <input type="checkbox"/> Dizziness                 |  |   |
| <input type="checkbox"/> Endometriosis             | Any Allergies: Please list: _____                          |   |
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Have you ever been treated for cancer?

If yes, explain therapy: \_\_\_\_\_

Within the last year, have you taken any prescription medications? yes no

If yes, list all prescriptions and problems for which you were taking them:

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**V. FAMILY HISTORY**

Is there a family history of infertility? yes    no

If yes, who (list all members and relationship to you):

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Is there a history of hormonal disorders in your family? yes    no

If yes, list 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 drugs have you taken for infertility? Check all that apply:

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

Have you ever had varicocele repair? yes    no

If yes, when?

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Have you ever had vasectomy reversal or repair? yes    no

If yes, when?

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Have you and your partner ever tried artificial insemination? yes    no

If yes: using your sperm? donor sperm?

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Have you and your partner ever tried in vitro fertilization? yes    no