IVF - Fertility Division
Women's Clinic, Ltd.

Male History

Today's Date: ________________

Patient: ____________________________________ Age: __________ PCP / Referring Physician: ______________________________

Name you would like us to use? _________________________________ If married, which marriage is this for you? ___________________

Employer: _____________________________ Job: ____________________________ Work Phone: ____________________________

Please review the following questions. Give details for all positive responses.

Questions			Details of positive responses
Fathered any pregnancies in the past	☐ Yes	☐ No	
Infertility in previous relationships	☐ Yes	☐ No	
Semen analysis performed	☐ Yes	☐ No	
Normal analysis	☐ Yes	☐ No	
Decreased Count	☐ Yes	☐ No	
Decreased Motility	☐ Yes	☐ No	
Abnormal Forms	☐ Yes	☐ No	
Hormone studies performed	☐ Yes	☐ No	
Urology evaluation in the past	☐ Yes	☐ No	
Varicocele surgery	☐ Yes	☐ No	
Hormonal or antibiotic treatment	☐ Yes	☐ No	
Inseminations with your sperm	☐ Yes	☐ No	
Inseminations with donor sperm	☐ Yes	☐ No	
Previous sterilization	☐ Yes	☐ No	
Sterilization reversal	☐ Yes	☐ No	
Difficulty with erection / ejaculation	☐ Yes	☐ No	
Discomfort with ejaculation	☐ Yes	☐ No	
Decreased sex drive	☐ Yes	☐ No	
Prostrate problem / infection	☐ Yes	☐ No	
Sexually Transmitted Diseases	☐ Yes	☐ No	{Gonorrhea, Chlamydia, Warts, Herpes, Urethritis, etc.}
Hepatitis or HIV	☐ Yes	☐ No	
Exposure to STD / Hepatitis / HIV	☐ Yes	☐ No	
Mumps involving the testicles	☐ Yes	☐ No	
Significant injury to testicle(s)	☐ Yes	☐ No	
Undescended testicle(s)	☐ Yes	☐ No	
Failure of testicles to develop	☐ Yes	☐ No	
Previous pelvic / groin surgery	☐ Yes	☐ No	
Unconscious from head injury	☐ Yes	☐ No	
Diabetes or other hormone disorders	☐ Yes	☐ No	
DES exposure as a fetus	☐ Yes	☐ No	
Significant illness in last 5 years	☐ Yes	☐ No	
Fever over 101^0 in last 6 months	☐ Yes	☐ No	
Prolonged exposure to high heat	☐ Yes	☐ No	

Male History (continued)

Please review the following questions. Give details for all positive responses.

Questions			Details of positive responses
Possible toxic exposures	☐ Yes	☐ No	____________________
Cigarette smoking	☐ Yes	☐ No	____________________
More than occasional alcohol intake	☐ Yes	☐ No	____________________
Past / present recreational drug use	☐ Yes	☐ No	____________________
Previous partner who used drugs	☐ Yes	☐ No	____________________

Is there a family history of any of the following?

Questions			Details of positive response
Diseases known to be passed genetically to children			____________________
Infants born with birth defects	☐ Yes	☐ No	____________________
Mental retardation	☐ Yes	☐ No	____________________
Repeat miscarriages	☐ Yes	☐ No	____________________
Cystic Fibrosis	☐ Yes	☐ No	____________________
Tay Sachs	☐ Yes	☐ No	____________________
Sickle Cell Disease	☐ Yes	☐ No	____________________
Hormone disorders	☐ Yes	☐ No	____________________
Other	☐ Yes	☐ No	____________________

List current medications:

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Physician notes:

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