

Patient's Name: _____ Date: _____

Male Medical History

Please complete with your male partner, if applicable.

- Have you ever been evaluated by a urologist? No Yes
- Have you previously conceived with another woman? No Yes If so, how many times? _____
- Have you had a semen analysis? No Yes
- Have you had any of the following sexually transmitted diseases or pelvic infections?

Chlamydia Gonorrhea Herpes Genital warts Syphilis HIV/AIDS Hepatitis Other

Have you ever been diagnosed with any of the following diseases?

- Diabetes Cancer _____
- Multiple sclerosis Urinary Infections _____
- High blood pressure If yes, any medications? _____
- Prostatic Infections

Have you had any of the following? If so, please explain.

- Yes No Retrograde ejaculation of sperm into the bladder
- Yes No History of mumps
- Yes No Difficulty with erections
- Yes No Difficulty with ejaculation
- Yes No History of undescended testicles
- Yes No Fever in the last three months
- Yes No Hernia Repair
- Yes No Surgery for Varicocele
- Yes No Bladder or penis surgery as a child
- Yes No Exposure to prolonged heat at the workplace
- Yes No Chemotherapy for cancer
- Yes No Exposure to radiation or chemicals at the workplace

- Are you allergic to any medications? No Yes If so, please list: _____
- List any medical problems: _____
- List any medications you have taken within the last three months: _____

Occupation/Habits/Leisure History

		Dates/Comments
Exposed to chemical or x-rays in work or hobby	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Please list		Amount per day or week
Caffeine	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Smoking	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Marijuana	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Nutritional supplements, herbs, etc.	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Please describe recreation/sports activities (frequency, length of time, etc.) _____

Patient's Name: _____ Date: _____

Family History

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Neimann-Pick disease | <input type="checkbox"/> Heart defect from birth |
| <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Infertility | <input type="checkbox"/> Fanconi anemia | <input type="checkbox"/> Down syndrome |
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Menopause before age 40 | <input type="checkbox"/> Familia Dysautonia | <input type="checkbox"/> Other chromosomal problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Neurologic (brain/spine) | <input type="checkbox"/> Marfan syndrome |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Neural tube defect | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Tay-sachs disease | <input type="checkbox"/> Bone/skeletal defects | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Canavan disease | <input type="checkbox"/> Dwarfism | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Bloom syndrome | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Galactosemia |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Gaucher disease | <input type="checkbox"/> Learning problems | <input type="checkbox"/> Deafness/Blindness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Polycystic kidney disease | <input type="checkbox"/> Color blindness |

What is Your Ancestry?

- | | | |
|--|---|--|
| <input type="checkbox"/> African American | <input type="checkbox"/> American Indian | <input type="checkbox"/> Ashkenazi |
| <input type="checkbox"/> Asian-American | <input type="checkbox"/> Cajun/French | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Eastern European | <input type="checkbox"/> Hispanic/Caribbean | <input type="checkbox"/> Northern European |
| <input type="checkbox"/> Southern European | <input type="checkbox"/> Other Specify | |