AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE
Infertility History Form

FOR OFFICE USE ONLY

IMPORTANT:
Please complete this form and
<u>Bring it with you to your scheduled visit.</u>

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/Male Partner
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 ____
☐ Web Site ____
☐ 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)

____
____
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____
____

PART II: FEMALE HISTORY AND INFORMATION

Reason for Visit: ☐ Infertility Evaluation ☐ Sperm 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.? ☐ No ☐ Yes ____________________

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? _______
* Any Pregnancies with Birth Defects? ☐ No ☐ Yes – explain ____

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/D&C/ Complications	Current Partner?
1. ______________	_____________	____________________________	___________________________	Y N
2. ______________	_____________	____________________________	___________________________	Y N
3. ______________	_____________	____________________________	___________________________	Y N
4. ______________	_____________	____________________________	___________________________	Y N
5. ______________	_____________	____________________________	___________________________	Y N
6. ______________	_____________	____________________________	___________________________	Y 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 to 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

Contraceptive History

☐ None ☐ Condoms – dates of use__________ ☐ Diaphragm – dates of use__________ ☐ IUD – dates of use_________
☐ 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? _________________________ ☐ Foam or jelly
☐ Tubal sterilization procedure (tubes tied) – date (month/year) ______/______ ☐ Tubes untied – date (month/year) ____/____

* Did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't know

Sexual History

* 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®, 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? ☐ No ☐ Yes – date______ Result: ☐ normal ☐abnormal – explain________________
Do you perform breast self exams? ☐ Yes ☐ No

Medical History
* Are you allergic to any medications? ☐ No ☐ Yes (Please list and describe reactions) ________________________________
____
____

* Are you allergic to any foods (peanuts, eggs, etc.)? ☐ No ☐ 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? ☐ No ☐ Yes (Please list) _________________
____

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

* Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐ Don't know
Other childhood diseases:____

Vaccinations
* Chickenpox (Varicella): ☐ No ☐ Yes (dates____________) ☐ Don't know
* MMR – Measles, Mumps and Rubella (German Measles): ☐ No ☐ Yes (dates____________) ☐ Don't know
* BCG (Tuberculosis): ☐ No ☐ Yes (dates____________) ☐ Don't know
* Hepatitis B: ☐ No ☐ Yes (dates____________) ☐ Don't know
* Polio: ☐ No ☐ Yes (dates____________) ☐ Don't know
* Hepatitis A: ☐ No ☐ Yes (dates____________) ☐ Don't know
* Tetanus: ☐ No ☐ Yes (dates____________) ☐ Don't know
* Influenza: ☐ No ☐ Yes (dates____________) ☐ Don't know

Social History
* How many caffeinated beverages (coffee, tea, soda) do you drink every day?_____ ☐ None
* Do you smoke cigarettes: ☐ No ☐ Yes How many/day?_____ How many years?______ ☐ Quit – when?______________
* Do you drink alcohol? ☐ No ☐ Yes
☐ Beer - # per week______ ☐ Wine - # per week ☐ Liquor - # per week
* Do you use marijuana, cocaine, or any other similar drug? ☐ No ☐ Yes (describe_________________________________)
* Do you exercise? ☐ No ☐ Yes (describe____)
* Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes (describe_______________________________)

Physician Notes (for office use only)____
____
____
____

Surgical History

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

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

*Did you have any anesthesia problems? ☐ No ☐ Yes (describe____)

Physical Symptoms

General:
- ☐ Recent weight gain or loss
- ☐ Anorexia/Bulimia
- ☐ Lack of energy
- ☐ Fever/Chills
- ☐ 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

Respiratory:
- ☐ Shortness of breath
- ☐ Asthma ☐ Bronchitis
- ☐ Pneumonia ☐ Tuberculosis
- ☐ Bloody cough
- ☐ 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

Breasts:
- ☐ Discharge (clear?__ bloody?__ milky?)
- ☐ Lumps ☐ Pain ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants (saline?___ silicone?___)
- ☐ Other___________________
- ☐ None

Neurological Problems:
- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory loss
- ☐ Other___________________
- ☐ None

Gastrointestinal:
- ☐ Nausea/Vomiting ☐ Ulcers
- ☐ Hepatitis ☐ Diarrhea
- ☐ Blood in your stools ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Other___________________
- ☐ None

Genito-Urinary:
- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination ☐ Leaking urine
- ☐ Blood in the urine
- ☐ Herpes
- ☐ Other___________________
- ☐ None

Skin/Extremities:
- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excessive hair growth
- ☐ Other___________________
- ☐ None

Musculoskeletal:
- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other__________________________
- ☐ None

Hematologic:
- ☐ Blood clotting disorder/Blood clot
- ☐ Sickle Cell Anemia ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions (dates/reasons________________)
- ☐ Other__________________________
- ☐ None

Cardiovascular:
- ☐ Palpitations/Skipped beats
- ☐ Chest pain ☐ Heart attack
- ☐ Stroke ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse (Need antibiotics before dental procedures?) Y N
- ☐ Other______________________
- ☐ None

Mental Health Problems:
- ☐ Depression ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other__________________________
- ☐ None

Physician Notes (for office use only) ____________________________________
____
____
____
____

Family History

	Living		Cause of Death/Age at Death
* Mother	☐ Yes – age___	☐ No	________________________
* Father	☐ Yes – age___	☐ No	________________________
* Brother(s)	☐ Yes – age___	☐ No	________________________
	☐ Yes – age___	☐ No	________________________
* Sister(s)	☐ Yes – age___	☐ No	________________________
	☐ Yes – age___	☐ No	________________________
* Maternal Grandmother	☐ Yes – age___	☐ No	________________________
* Maternal Grandfather	☐ Yes – age___	☐ No	________________________
* Paternal Grandmother	☐ Yes – age___	☐ No	________________________
* Paternal Grandfather	☐ Yes – age___	☐ No	________________________

Disorders in Your Family

		Relationship to You		
* Breast cancer	☐ Yes	______________________	☐ No	☐ Don't Know
* Ovarian cancer	☐ Yes	______________________	☐ No	☐ Don't Know
* Colon cancer	☐ Yes	______________________	☐ No	☐ Don't Know
* Other cancer	☐ Yes	______________________	☐ No	☐ Don't Know
* Diabetes	☐ Yes	______________________	☐ No	☐ Don't Know
* Thyroid problems	☐ Yes	______________________	☐ No	☐ Don't Know
* Heart disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Blood clots	☐ Yes	______________________	☐ No	☐ Don't Know
* Obesity	☐ Yes	______________________	☐ No	☐ Don't Know
* Psychiatric problems	☐ Yes	______________________	☐ No	☐ Don't Know
* Tuberculosis	☐ Yes	______________________	☐ No	☐ Don't Know
* Endometriosis	☐ Yes	______________________	☐ No	☐ Don't Know
* Infertility	☐ Yes	______________________	☐ No	☐ Don't Know
* Menopause before age 40	☐ Yes	______________________	☐ No	☐ Don't Know
* Birth defects	☐ Yes	______________________	☐ No	☐ Don't Know
* Cystic Fibrosis	☐ Yes	______________________	☐ No	☐ Don't Know
* Tay-Sachs disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Canavan disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Bloom syndrome	☐ Yes	______________________	☐ No	☐ Don't Know
* Gaucher disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Niemann-Pick disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Fanconi Anemia	☐ Yes	______________________	☐ No	☐ Don't Know
* Familial Dysautonia	☐ Yes	______________________	☐ No	☐ Don't Know
* Muscular Dystrophy	☐ Yes	______________________	☐ No	☐ Don't Know
* Neurologic (brain/spine)	☐ Yes	______________________	☐ No	☐ Don't Know
* Neural Tube Defects	☐ Yes	______________________	☐ No	☐ Don't Know
* Bone/Skeletal Defects	☐ Yes	______________________	☐ No	☐ Don't Know
* Dwarfism	☐ Yes	______________________	☐ No	☐ Don't Know
* Developmental delay	☐ Yes	______________________	☐ No	☐ Don't Know
* Learning problems	☐ Yes	______________________	☐ No	☐ Don't Know
* Polycystic kidney disease	☐ Yes	______________________	☐ No	☐ Don't Know
* Heart defect from birth	☐ Yes	______________________	☐ No	☐ Don't Know
* Down syndrome	☐ Yes	______________________	☐ No	☐ Don't Know
* Other chromosome defects	☐ Yes	______________________	☐ No	☐ Don't Know
* Marfan syndrome	☐ Yes	______________________	☐ No	☐ Don't Know
* Hemophilia	☐ Yes	______________________	☐ No	☐ Don't Know
* Sickle Cell Anemia	☐ Yes	______________________	☐ No	☐ Don't Know
* Thalassemia	☐ Yes	______________________	☐ No	☐ Don't Know
* Galactosemia	☐ Yes	______________________	☐ No	☐ Don't Know
* Deafness/Blindness	☐ Yes	______________________	☐ No	☐ Don't Know
* Color Blindness	☐ Yes	______________________	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes	______________________	☐ No	☐ Don't Know

☐ None of the above ☐ Other (Specify____

What is your ancestry?

____ African-American

____ American Indian/Native American

____ Ashkenazi Jewish

____ Asian-American

____ Cajun/French Canadian

____ Caucasian

____ Eastern European

____ Hispanic/Caribbean

____ Northern European

____ Southern European

____ Other (specify________________)

Would you like to be screened for:

____ Cystic Fibrosis: __Yes __No

____ Sickle Cell Anemia: __Yes __No

____ Tay-Sachs Disease: __Yes __No

____ Thalassemia: __Yes __No

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):

☐ Intrauterine insemination:	**# of cycles** ________	**Dates** (mo/yr) (mo/yr) From__/___ to __/___	**Outcome** __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Clomiphene citrate with timed intercourse: Maximum # tablets per day?_____	________	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Clomiphene citrate with insemination: Maximum # tablets per day?_____	________	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Daily fertility drug injections with insemination?: Maximum # vials per day?_____	________	From__/___ to __/___	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Completed in vitro fertilization cycle(s): 1. # eggs___ # embryos transferred__ # frozen___ 2. # eggs___ # embryos transferred__ # frozen___ 3. # eggs___ # embryos transferred__ # frozen___ 4. # eggs___ # embryos transferred__ # frozen___	________	______/______ ______/______ ______/______ ______/______	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
☐ Frozen embryo transfers: 1. # embryos transferred _____ 2. # embryos transferred _____ 3. # embryos transferred _____ 4. # embryos transferred _____	________	______/______ ______/______ ______/______ ______/______	__Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant __Pregnant__Delivered__Ectopic__ Miscarriage __ Not Pregnant
Canceled in vitro fertilization attempt(s):	________		
☐ 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? ☐ No ☐ Yes – For how long? _________________ How often? ________________________
- 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** ______________________

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? Yes___ No___
* Have you had a semen analysis? ☐ Yes ☐ No
* Do you have difficulty with erections? ☐ 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 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____________________
* Have you had a history of undescended testicles? ☐ Yes – One side____ Both____ ☐ No
* Do you have scrotal or testicular pain? ☐ Yes ☐ No
* Did you have mumps after puberty? ☐ Yes ☐ No
* Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No

*Have you been diagnosed with any of the following diseases?
☐ Diabetes Mellitus – Yes___ No___ ☐ Cancer – Yes___ No___
☐ Multiple Sclerosis – Yes___ No___ ☐ Other neurologic problems – Yes___ No___
☐ Prostatic infections – Yes___ No___ ☐ Urinary infections – Yes___ No___
☐ High Blood Pressure – Yes___ No___ If yes, any medications?__________________________

* Have you had any fever 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 surgery for varicocele repair? ☐ Yes ☐ No
* Have you had hernia surgery? ☐ Yes ☐ No
* Did you undergo any bladder or penis surgery as a child? ☐ 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 for cancer? ☐ Yes ☐ No
* Are you allergic to any medications? ☐ No ☐ 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? ☐ No ☐ Yes How many/day? How many years?____ ☐ Quit – when?______________________
* Do you drink alcohol? ☐ No ☐ Yes
  ☐ Beer - # per week___ ☐ Wine - # per week___ ☐ Liquor - # per week___
* Do you use marijuana, cocaine or any other similar drug? ☐ No ☐ Yes (describe__________________________________)
* Do you use herbal medicines/vitamins or health food store supplements? ☐ No ☐ Yes (describe_________________________)
* Are you aware of any radiation/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____

Physician Notes (for office use only)
____
____

Disorders in Your Family

Disorder	Yes	Relationship to You	No	Don't Know
* Cystic Fibrosis	☐ Yes	____________________	☐ No	☐ Don't Know
* Tay-Sachs disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Canavan disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Bloom syndrome	☐ Yes	____________________	☐ No	☐ Don't Know
* Gaucher disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Niemann-Pick disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Fanconi Anemia	☐ Yes	____________________	☐ No	☐ Don't Know
* Familial Dysautonia	☐ Yes	____________________	☐ No	☐ Don't Know
* Muscular Dystrophy	☐ Yes	____________________	☐ No	☐ Don't Know
* Neurologic (brain/spine)	☐ Yes	____________________	☐ No	☐ Don't Know
* Neural Tube Defects	☐ Yes	____________________	☐ No	☐ Don't Know
* Bone/Skeletal Defects	☐ Yes	____________________	☐ No	☐ Don't Know
* Dwarfism	☐ Yes	____________________	☐ No	☐ Don't Know
* Developmental delay	☐ Yes	____________________	☐ No	☐ Don't Know
* Learning problems	☐ Yes	____________________	☐ No	☐ Don't Know
* Polycystic kidney disease	☐ Yes	____________________	☐ No	☐ Don't Know
* Heart defect from birth	☐ Yes	____________________	☐ No	☐ Don't Know
* Down syndrome	☐ Yes	____________________	☐ No	☐ Don't Know
* Other chromosome defects	☐ Yes	____________________	☐ No	☐ Don't Know
* Marfan syndrome	☐ Yes	____________________	☐ No	☐ Don't Know
* Hemophilia	☐ Yes	____________________	☐ No	☐ Don't Know
* Sickle Cell Anemia	☐ Yes	____________________	☐ No	☐ Don't Know
* Thalassemia	☐ Yes	____________________	☐ No	☐ Don't Know
* Galactosemia	☐ Yes	____________________	☐ No	☐ Don't Know
* Deafness/Blindness	☐ Yes	____________________	☐ No	☐ Don't Know
* Color Blindness	☐ Yes	____________________	☐ No	☐ Don't Know
* Hemochromatosis	☐ Yes	____________________	☐ No	☐ Don't Know

☐ None of the above ☐ Other (Specify____

What is your ancestry?

____ African-American

____ American Indian/Native American

____ Ashkenazi Jewish

____ Asian-American

____ Cajun/French Canadian

____ Caucasian

____ Eastern European

____ Hispanic/Caribbean

____ Northern European

____ Southern European

____ Other
(specify________________)

Would you like to be screened for:

____ Cystic Fibrosis: __Yes __No

____ Sickle Cell Anemia: __Yes __No

____ Tay-Sachs Disease: __Yes __No

____ Thalassemia: __Yes __No

SPOUSE/MALE PARTNER'S SIGNATURE____ **DATE**________________

I confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE____**DATE**_______________

Physician Notes (for office use only) ____

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 ______

Insurance Company ____ Insurance ID#_______________________

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment – title(s), location, brief description, number of years employed:

_________________________ _________________________ _________________________ _____________

_________________________ _________________________ _________________________ _____________

_________________________ _________________________ _________________________ _____________

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

☐ Heat ☐ Toxic Fumes ☐ Other (specify): __________________

☐ Chemicals ☐ Nuclear Radiation __________________________________

III. MEDICAL HISTORY

	YES	NO
Weight _________ Height _________ Blood Type (if known) _________		
Have you lost greater than 20 pounds of weight in the last year? ……………………………………………………………	☐	☐
Do you follow a particular food diet or have any special dietary habits?……………………………………………………	☐	☐
If yes, specify:____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:		
Exercise: _________ Hrs/Week _________ Age _________ Exercise _________ Hrs/Week ________ Age ________		
Do you frequently take saunas or steam baths?…………………………………………………………………………	☐	☐
Have you ever had surgery in the pelvic area? …………………………………………………………………………	☐	☐
If yes, specify date and type of surgery: ____		

Do you have or have you had (check all that apply):

☐ Anemia
☐ Appendicitis
☐ Arthritis
☐ Blood Transfusion
☐ Breast Milky Discharge
☐ Breast Soreness
☐ Breast Tenderness
☐ Cancer? Specify_________________
____
☐ Chlamydia
☐ Chronic Bronchitis
☐ Chronic Headaches
☐ Colitis
☐ Cystic Fibrosis
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Gallbladder Problems
☐ Gonorrhea
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Kidney Infection
☐ Liver Problems
☐ Loss of Balance
☐ Measles: German
☐ Measles: Regular
☐ Mumps
☐ Mumps with Testes Involved
☐ Neurological Problems
☐ Nongonococcal Urethritis
☐ Parasitic infection
☐ Pneumonia
☐ Prostatitis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Syphilis
☐ Testes infection
☐ Testes Injury
☐ Testes Tumor
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Visual Disturbances
☐ Any Allergies? List _______________
____

	YES	NO
Have you ever been treated for cancer?	☐	☐
If yes, explain therapy:_______________		
Within the last year, have you taken any prescription medications?	☐	☐
If yes, list all prescriptions and problems for which you were taking them:_______________		
Are you taking any over-the-counter medications on a regular basis?	☐	☐
If yes, list all medications and diagnoses: _______________		
Have you had a high fever (over 102°F) during the past 3-4 months?	☐	☐

Do you use or have you ever used (check all that apply):

☐ Alcohol – How many glasses per week do you usually drink? Wine_________ Beer_________ Cocktails_________

☐ Cigarettes – Number of packs per day_________

☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please Discuss this directly with your physician. Specify: _______________

IV. SEXUAL HISTORY

	YES	NO
Are you circumcised?	☐	☐
When you were a child, were both testes descended into the scrotum?	☐	☐
At what age did you begin shaving regularly or start to grow a beard? _______________		
How many times have you been married? _______________		
Have you ever produced a child with another partner?	☐	☐
If yes, how long did it take to produce a child? _______________ When was this (dates)? _______________		
Have you ever *tried* to produce a child with another partner?	☐	☐
Do you have trouble getting an erection?	☐	☐
Maintaining an erection?	☐	☐
Do you have trouble with ejaculations?	☐	☐
If yes, ☐ Premature ejaculations ☐ Retrograde ejaculations		
Do you feel that some of your ejaculate is deposited in the vagina?	☐	☐
Do you ever have orgasms without ejaculation during masturbation?	☐	☐
Do you have any discharge from the penis?	☐	☐
How many times per week do you and your partner now have intercourse? _______________		
How many times do you have intercourse around ovulation? _______________		
Have you noticed a change in your sexual drive recently?	☐	☐

V. FAMILY HISTORY

	YES	NO
Is there a family history of infertility?	☐	☐
If yes, who (list all members and relationship to you): _______________		
Is there a history of hormonal disorders in your family?	☐	☐
If yes, list who (relationship to you) and what type: _______________		

VI. HISTORY OF FERTILITY THERAPY

	YES	NO
Have you been treated for infertility before? ……	☐	☐

If yes, who was your physician? ____________________

What cause of infertility was diagnosed? ____________________

What drugs have you taken for infertility? Check all that apply:

- ☐ clomiphene citrate (Serophene®, Clomid®)
- ☐ hMG
- ☐ tamoxifen
- ☐ testolactone
- ☐ bromocriptine (Parlodel®)
- ☐ testosterone or Male Hormone
- ☐ hCG
- ☐ fluoxymesterone (Halotestin®)
- ☐ GnRH or LHRH (Factrel®)
- ☐ FSH
- ☐ Other – Specify ____________________
- ☐ None

	YES	NO
Have you ever had varicocele repair? ……	☐	☐

If yes, when? ____________________

	YES	NO
Have you ever had vasectomy reversal repair? ……	☐	☐

If yes, when? ____________________

	YES	NO
Have you and your partner ever tried artificial insemination? ……	☐	☐

If yes: using ☐ your sperm? ☐ donor sperm?

	YES	NO
Have you and your partner ever tried in vitro fertilization? ……	☐	☐

If yes, when and explain____________________

Which of the following tests have you had performed? Check all that apply and the results, if known:

Test	When?	Results:
☐ Semen Analysis	When? ________	Results: ____________
☐ Chlamydia Test	When? ________	Results: ____________
☐ Mycoplasma Test	When? ________	Results: ____________
☐ Antibody Test	When? ________	Results: ____________
☐ Hamster Egg Test	When? ________	Results: ____________
☐ Chromosome Test	When? ________	Results: ____________
☐ Testicular Biopsy	When? ________	Results: ____________
☐ X-ray or Ultrasound of Testes	When? ________	Results: ____________
☐ Hormonal Tests (FSH, LH, prolactin, testosterone)	When? ________	Results: ____________
☐ Thyroid Tests	When? ________	Results: ____________
☐ Other – Specify ____________	When? ________	Results: ____________

	YES	NO
Is your partner currently seeing a doctor for evaluation of infertility? ……	☐	☐

If yes, specify physician name and location: ____________________

	YES	NO
Does the doctor feel that your partner has an infertility problem? ……	☐	☐

If yes, what is the diagnosis and how is she being treated? ____________________

____

	YES	NO
Has she ever had children with another man? ……	☐	☐

If yes, when? ____________________

FOR PHYSICIAN USE ONLY

VII. PHYSICAL FINDINGS

VIII. SURGERY

IX. OTHER COMMENTS

X. COURSE OF ACTION