## AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

Infertility History Form

**IMPORTANT:**
Please complete this form and bring it with you to your scheduled visit.

This form was developed by the American Society for Reproductive Medicine to assist physicians and patients in obtaining a complete infertilty 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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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  
  Address

- [ ] Web Site

- [ ] Insurance (Name of Insurance)

Who is your Ob/Gyn?

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone ()</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address

Who is your Primary Care Physician?

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone ()</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address

Page 1
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 cafffeinated 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)
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
Page 3
Surgical History
* Have you had any surgeries? □ No □ Yes (List all surgeries in chronologic order.)

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason and Type of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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

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

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

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

Mental Health Problems:
- □ Depression □ Anxiety disorder
- □ Schizophrenia
- □ 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

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

Respiratory:
- □ Shortness of breath
- □ Asthma
- □ Bronchitis
- □ Pneumonia
- □ Tuberculosis
- □ Bloody cough
- □ Other
- □ None

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

Skin/Extremities:
- □ Unexplained rash/inflammation
- □ Acne
- □ Skin cancer
- □ Burn injury
- □ Moles changing in appearance
- □ Excessive hair growth
- □ 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

Physician Notes (for office use only) __________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
Family History

- Mother
  - Yes – age__
  - No ________________________
- Father
  - Yes – age__
  - No ________________________
- Brother(s)
  - Yes – age__
  - No ________________________
- Sister(s)
  - 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

- Breast cancer
  - Yes ______________________
  - No ______________________
- Ovarian cancer
  - Yes ______________________
  - No ______________________
- Colon cancer
  - Yes ______________________
  - No ______________________
- Other cancer
  - Yes ______________________
  - No ______________________
- Diabetes
  - Yes ______________________
  - No ______________________
- Thyroid problems
  - Yes ______________________
  - No ______________________
- Heart disease
  - Yes ______________________
  - No ______________________
- Blood clots
  - Yes ______________________
  - No ______________________
- Obesity
  - Yes ______________________
  - No ______________________
- Psychiatric problems
  - Yes ______________________
  - No ______________________
- Tuberculosis
  - Yes ______________________
  - No ______________________
- Endometriosis
  - Yes ______________________
  - No ______________________
- Infertility
  - Yes ______________________
  - No ______________________
- Menopause before age 40
  - Yes ______________________
  - No ______________________
- Birth defects
  - Yes ______________________
  - No ______________________
- Cystic Fibrosis
  - Yes ______________________
  - No ______________________
- Tay-Sachs disease
  - Yes ______________________
  - No ______________________
- Canavan disease
  - Yes ______________________
  - No ______________________
- Bloom syndrome
  - Yes ______________________
  - No ______________________
- Gaucher disease
  - Yes ______________________
  - No ______________________
- Niemann-Pick disease
  - Yes ______________________
  - No ______________________
- Fanconi Anemia
  - Yes ______________________
  - No ______________________
- Familial Dysautonemia
  - Yes ______________________
  - No ______________________
- Muscular Dystrophy
  - Yes ______________________
  - No ______________________
- Neurologic (brain/spine)
  - Yes ______________________
  - No ______________________
- Neural Tube Defects
  - Yes ______________________
  - No ______________________
- Bone/Skeletal Defects
  - Yes ______________________
  - No ______________________
- Dwarfism
  - Yes ______________________
  - No ______________________
- Developmental delay
  - Yes ______________________
  - No ______________________
- Learning problems
  - Yes ______________________
  - No ______________________
- Polycystic kidney disease
  - Yes ______________________
  - No ______________________
- Heart defect from birth
  - Yes ______________________
  - No ______________________
- Down syndrome
  - Yes ______________________
  - No ______________________
- Other chromosome defects
  - Yes ______________________
  - No ______________________
- Marfan syndrome
  - Yes ______________________
  - No ______________________
- Hemophilia
  - Yes ______________________
  - No ______________________
- Sickle Cell Anemia
  - Yes ______________________
  - No ______________________
- Thalassemia
  - Yes ______________________
  - No ______________________
- Galactosemia
  - Yes ______________________
  - No ______________________
- Deafness/Blindness
  - Yes ______________________
  - No ______________________
- Color Blindness
  - Yes ______________________
  - No ______________________
- Hemochromatosis
  - Yes ______________________
  - No ______________________

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

☐ None of the above  ☐ Other (Specify__________________________________________

Page 5
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):

<table>
<thead>
<tr>
<th>Treatment Description</th>
<th># of cycles</th>
<th>Dates (mo/yr) (mo/yr)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrauterine insemination</td>
<td>______</td>
<td>From__/___ to <strong>/</strong>_</td>
<td><em>Pregnant</em> <em>Delivered</em> <em>Ectopic</em> <em>Miscarriage</em> _Not Pregnant</td>
</tr>
<tr>
<td>Clomiphene citrate with timed intercourse:</td>
<td>______</td>
<td>From__/___ to <strong>/</strong>_</td>
<td><em>Pregnant</em> <em>Delivered</em> <em>Ectopic</em> <em>Miscarriage</em> _Not Pregnant</td>
</tr>
<tr>
<td>Clomiphene citrate with insemination:</td>
<td>______</td>
<td>From__/___ to <strong>/</strong>_</td>
<td><em>Pregnant</em> <em>Delivered</em> <em>Ectopic</em> <em>Miscarriage</em> _Not Pregnant</td>
</tr>
<tr>
<td>Daily fertility drug injections with insemination?:</td>
<td>______</td>
<td>From__/___ to <strong>/</strong>_</td>
<td><em>Pregnant</em> <em>Delivered</em> <em>Ectopic</em> <em>Miscarriage</em> _Not Pregnant</td>
</tr>
<tr>
<td>Completed in vitro fertilization cycle(s):</td>
<td>______</td>
<td>______ /____</td>
<td><em>Pregnant</em> <em>Delivered</em> <em>Ectopic</em> <em>Miscarriage</em> _Not Pregnant</td>
</tr>
<tr>
<td>Frozen embryo transfers:</td>
<td>______</td>
<td>______ /____</td>
<td><em>Pregnant</em> <em>Delivered</em> <em>Ectopic</em> <em>Miscarriage</em> _Not Pregnant</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Relationship to You</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Cystic Fibrosis</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Tay-Sachs disease</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Canavan disease</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Bloom syndrome</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Gaucher disease</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Niemann-Pick disease</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Fanconi Anemia</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Familial Dysautonnia</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Muscular Dystrophy</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Neurologic (brain/spine)</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Neural Tube Defects</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Bone/Skeletal Defects</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Dwarfism</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Developmental delay</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Learning problems</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Polycystic kidney disease</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Heart defect from birth</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Down syndrome</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Other chromosome defects</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Marfan syndrome</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Hemophilia</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Sickle Cell Anemia</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Thalassemia</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Galactosemia</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Deafness/Blindness</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Color Blindness</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>* Hemochromatosis</td>
<td>Yes ______________________ No Don't Know</td>
</tr>
<tr>
<td>** None of the above **</td>
<td></td>
</tr>
<tr>
<td>** Other (Specify________________**</td>
<td></td>
</tr>
</tbody>
</table>

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
- [ ] 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: ________________________________________________________________ | | |

If you have or have 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 _______________
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

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

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

Have you been treated for infertility before? ................................................................. □ NO

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®) ☐ hCG
☐ hMG ☐ fluoxymesterone (Halotestin®)
☐ tamoxifen ☐ GnRH or LHRH (Factrel®)
☐ testolactone ☐ FSH
☐ bromocriptine (Parlodel®) ☐ Other – Specify _______________________________
☐ testosterone or Male Hormone ☐ None

Have you ever had varicocele repair? .............................................................................. □ NO

If yes, when? ___________________________________________________________________

Have you ever had vasectomy reversal repair? ............................................................ □ NO

If yes, when? ___________________________________________________________________

Have you and your partner ever tried artificial insemination? .................................... □ NO

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

Have you and your partner ever tried in vitro fertilization? ........................................ □ NO

If yes, when and explain___________________________________________________________________________________

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

☐ 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: _______________________

Is your partner currently seeing a doctor for evaluation of infertility? .......................... □ NO

If yes, specify physician name and location: __________________________________________

Does the doctor feel that your partner has an infertility problem? ............................. □ NO

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

______________________________________________________________________________

Has she ever had children with another man? ............................................................. □ NO

If yes, when? ___________________________________________________________________