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Date: _____
Chart #: _____

MALE INFERTILITY INTAKE FORM

Patient Name: _____

Date of Birth: _____

MEDICAL HISTORY AND INFORMATION

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: When and where? _____ No
Do you have difficulty with erections? Yes No
Do you have retrograde ejaculation of sperm into the bladder? Yes No
Do you have a history of undescended testicles? Yes: One side _____, both _____ No
Do you have scrotal or testicular pain? Yes No
Did you have the mumps after puberty? Yes No
Have you had prior injury to your testicles requiring hospitalization? Yes No
Do you wear boxers _____ or briefs _____

Have you been diagnosed with any of the following diseases?

___ Diabetes Mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No	___ Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
___ Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	___ Other Neurologic problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
___ Prostatic Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	___ Urinary Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
___ High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, any medications? _____	

Have you had any fever in the last three 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? Yes No
(Please list and describe reactions): _____

Does your wife have any infertility issues? Yes No
Do you have headaches? Yes No
Do you have breast swelling? Yes No
Do you have vision changes? Yes No
Infections in the testicles(s)? Yes No

SEXUAL HISTORY:

How many times do you have intercourse per week? _____ times per week None N/A
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? Yes (check all that apply) No

<input type="checkbox"/> Chlamydia (date): _____	<input type="checkbox"/> Genital warts/HPV (date): _____
<input type="checkbox"/> Gonorrhea (date): _____	<input type="checkbox"/> HIV/AIDS (date): _____
<input type="checkbox"/> Herpes (date): _____	<input type="checkbox"/> Hepatitis (date): _____
<input type="checkbox"/> Syphilis (date): _____	<input type="checkbox"/> Other (date): _____

MEDICAL HISTORY

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 medicine.

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 types, dates, and treatments)

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____

Did you have either of these childhood illnesses?

- Chickenpox(Varicella) German measles(Rubella) Don't know

SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) 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(#/week)___ Wine(#/week)___ Liquor(#/week)___
Do you use marijuana, cocaine, or any other similar drugs? 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 chronological order)

<u>Year</u>	<u>Reason and Type of Surgery</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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 in ears
- Hearing loss / deafness
- Other: _____
- None

Respiratory

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

Endocrine/Hormonal

- Diabetes
- Thyroid gland problems
- Rapid weight gain/loss
- Excessive hunger/thirst
- Temperature intolerance
hot flashes/feeling cold
- Other: _____
- None

Neurological

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

Gastrointestinal

- Nausea/vomiting Ulcers
- Hepatitis Diarrhea
- Blood in stools Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn's)
- Other: _____

Genito-Urinary

- Bladder infections
- Kidney infections
- Frequent infections
- Leaking urine
- Blood in urine
- Herpes
- Other: _____

Skin/Extremities

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other: _____

Musculoskeletal

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other _____

Hematologic

- Blood clotting disorder/blood clot
- Sickle Cell Anemia
- Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reason) _____

Cardiovascular

- Palpitations/skipped beats
- Chest pain Heart attack
- Stroke Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse (need antibiotics before dental procedures__?)

None

Other _____

None

Other _____

None

Mental Health Problems

- Depression Anxiety disorder Schizophrenia Other None

Physician notes (for office use only)

Family History

- | | | |
|----------------------|---|-----------------------------|
| Mother | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |
| Father | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |
| Brother(s) | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |
| Sister(s) | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |
| | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |
| Maternal Grandmother | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |
| Maternal Grandfather | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |
| Paternal Grandmother | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |
| Paternal Grandfather | <input type="checkbox"/> Yes – age ____ | <input type="checkbox"/> No |

Living

Cause of death/age at death

What is your Ancestry?

- | | | |
|--|--|--|
| <input type="checkbox"/> African-American | <input type="checkbox"/> American-Indian/Native American | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Ashkenazi Jewish | <input type="checkbox"/> Asian-American | <input type="checkbox"/> Eastern European |
| <input type="checkbox"/> Cajun/French Canadian | <input type="checkbox"/> Hispanic/Caribbean | <input type="checkbox"/> Northern European |
| <input type="checkbox"/> Southern European | <input type="checkbox"/> Other (specify) _____ | |

Would you like to be screened for:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Tay-Sachs Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Thalassemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Disorders in your family:

Relationship to you

Colon Cancer	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Other Cancer _____	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Diabetes	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Thyroid Problems	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Heart problems	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Blood clots	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Obesity	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Psychiatric problems	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Tuberculosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Infertility	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Birth defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Cystic Fibrosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Tay-Sachs disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Canavan disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Bloom syndrome	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Gaucher Disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Niemann-Pick disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Fanconi Anemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Familial Dysautonomia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Muscular Dystrophy	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Neurologic (brain/spine)	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Neural Tube defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Bone/skeletal defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Dwarfism	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Developmental delay	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Polycystic kidney disease	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Heart defect from birth	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Down syndrome	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Other chromosome defects	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Marfan syndrome	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Hemophilia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Sickle Cell Anemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Thalassemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Galactosemia	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Deafness/Blindness	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Color Blindness	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Hemochromatosis	<input type="checkbox"/> Yes	_____	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
None of the above	<input type="checkbox"/> Other (specify) _____			

EMOTIONAL STATUS

- ♦ On a scale of 1-10 (with 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 anti-depressant/anti-anxiety medications you are currently taking: _____

