

NORTH HOUSTON CENTER FOR REPRODUCTIVE MEDICINE

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Address _____

Telephone: Home _____ Work _____ Cell _____

Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____

II. TRAVEL/ WORK AND GENERAL BACKGROUND

All present employment –

Present Employment / Title	Location	Brief Description	Number of years

III. MEDICAL HISTORY

Weight _____ Height _____ Blood type (if known) _____ YES NO

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 form and frequency of regular vigorous exercise (swimming, cycling, running) and age you began:

Exercise: _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age _____

Have you ever had surgery in the pelvic area?

If yes, specify date and type: _____

Have you ever received X-rays in the pelvic area for therapy or diagnosis?.....

If yes, explain: _____

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

- Anemia
- Appendicitis
- Arthritis
- Blood Transfusion
- Cancer? Specify _____
- Chlamydia
- Colitis
- Cystic Fibrosis
- Diabetes
- Epilepsy
- Gonorrhea
- Heart Disease
- Any Medication Allergies? List _____
- Hepatitis
- Herpes
- High Blood Pressure
- Liver Problems
- Mumps with Testes Involved
- Prostatitis
- Syphilis
- Testes Infection
- Testes Injury
- Testes Tumor
- Thyroid Problems
- Ulcers

List all current medications-both prescription and non-prescription _____

YES NO

Have you had a high fever (over 101°F) during the past 3 – 4 months?.....

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

- Cigarettes – Number of packs per day _____ Number of years _____
- Marijuana, cocaine, etc) specify _____
- How many servings of alcohol per week do you usually drink? _____

IV. SEXUAL HISTORY

Are you circumcised?.....

When you were a child, were both testes descended into the scrotum?.....

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 with sexual intercourse, ejaculations.....

If yes, please specify _____

V. FAMILY HISTORY

Is there a family history of: (if yes, specify which family member)

- Diabetes _____
- Birth Defects _____
- Cancer _____
- Heart Disease / strokes _____
- Blood clots or bleeding problems _____
- Hepatitis or liver disease _____
- Infertility _____
- Inherited or genetic diseases _____

IV. HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before?.....

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

