

MALE HISTORY

Height: _____ Weight: _____
Are you under the care of a urologist? ___No ___Yes Physician(s): _____
Have you been treated for infertility before? ___No ___Yes Physician(s): _____

Have you had a vasectomy: ___No ___Yes Date: _____ Physician: _____
Have you had a vasectomy reversal? ___No ___Yes Date: _____ Physician: _____
Have you had surgery for varicocele repair? ___No ___Yes Date: _____ Physician: _____

Do you have any children conceived with another partner? ___No ___Yes
How many children? _____ How long ago? _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Blood Transfusion (date ___/___/___) | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Hepatitis (date ___/___/___) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Disease (date ___/___/___) | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Testes Infection | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chickenpox (date ___/___/___) | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hernia (date ___/___/___) | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Chlamydia (date ___/___/___) | <input type="checkbox"/> Testes Tumor | <input type="checkbox"/> Testicular Pain |
| <input type="checkbox"/> Testes Injury (date ___/___/___) | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Scrotal Pain |
| <input type="checkbox"/> Herpes (date ___/___/___) | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Erection Difficulty |
| <input type="checkbox"/> Measles/Rubella (date ___/___/___) | <input type="checkbox"/> Mumps after Puberty | <input type="checkbox"/> Penis Pain |
| <input type="checkbox"/> Gonorrhea (date ___/___/___) | <input type="checkbox"/> Fever in last 3 months | <input type="checkbox"/> Penis Discharge |
| <input type="checkbox"/> Frequent Saunas/Steam baths | <input type="checkbox"/> Genital Warts/HPV | Exposure at work to: |
| <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Ejaculation Difficulty: | ___ Chemicals |
| <input type="checkbox"/> TB | ___ Premature | ___ Prolonged Heat |
| <input type="checkbox"/> Other _____ | ___ Retrograde | ___ Radiation |
| | | ___ Toxic Fumes |

FERTILITY TESTING AND TREATMENT

What DRUGS have you taken for infertility? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Clomiphene citrate (Serophene, Clomid) | <input type="checkbox"/> Fluoxymesterone (Halotestin) |
| <input type="checkbox"/> hMG (Pergonal) | <input type="checkbox"/> hCG (Profasi, A.P.L.) |
| <input type="checkbox"/> Tamoxifen | <input type="checkbox"/> Bromocriptine (Parlodel) |
| <input type="checkbox"/> Testolactone | <input type="checkbox"/> Urofollitropin or FSH (Metrodin) |
| <input type="checkbox"/> Testosterone or Male Hormone | <input type="checkbox"/> Other – Specify _____ |
| <input type="checkbox"/> GnRH or LHRH (Factrel) | |

What TESTING have you done for infertility: (Check all that apply)

- | | | |
|--|--------------------|------------------|
| <input type="checkbox"/> Testicular Biopsy | Date: ___/___/___ | Physician: _____ |
| <input type="checkbox"/> X-Ray or Ultrasound | Date: ___/___/___ | Physician: _____ |
| <input type="checkbox"/> Hormonal Test | Date: ___/___/___ | Physician: _____ |
| Results: FSH _____ LH _____ PRL _____ | Testosterone _____ | |

What TREATMENTS have you had for infertility? (Check all that apply)

- | | | |
|--|--------------------------------------|------------------|
| <input type="checkbox"/> Artificial Insemination | | |
| ___ Your sperm | # cycles _____ Date last cycle _____ | Physician: _____ |
| ___ Donor Sperm | # cycles _____ Date last cycle _____ | Physician: _____ |

SEMEN ANALYSIS

Date: ___/___/___ Lab: _____ mil/ml _____ % mot _____ Act _____ Prog _____ % Norm _____
Date: ___/___/___ Lab: _____ mil/ml _____ % mot _____ Act _____ Prog _____ % Norm _____

Pacific In Vitro Fertilization Institute

Date: _____ Patient Name: _____
DOB: _____ Partner Name: _____

MEDICAL HISTORY

Do you have any medical problems? No Yes – list dates and treatments
Type: _____ Date: ___/___/___ Treatment: _____
Type: _____ Date: ___/___/___ Treatment: _____

Are you allergic to any MEDICATION? No Yes – list all and describe reaction
Medication _____ Reaction: _____
Medication _____ Reaction: _____

Are you allergic to any FOODS? No Yes – list all and describe reaction
Food _____ Reaction: _____
Food _____ Reaction: _____

Are you taking any PRESCRIPTION MEDICATIONS? No Yes – list all
Prescription: _____ For: _____
Prescription: _____ For: _____

Are you taking any OVER-THE-COUNTER MEDICATION? No Yes – list all
Medication: _____ For: _____
Medication: _____ For: _____

Do you take any HERBAL MEDICATINS/VITAMINS or health food supplements? No Yes – list all
Medication: _____ For: _____
Medication: _____ For: _____

FAMILY HISTORY

List any members of your immediate family who have a history of infertility or breast cancer:
Relationship: _____ Condition: _____ Treatment: _____

SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) do you drink a day? _____ None
Do you smoke cigarettes? No Yes How many/day: _____ How many years: _____
Age started: _____ Quitting? _____

Do you drink alcohol? No Yes #Beer/week _____ #Wine per week _____ #Liquor/week _____

Do you use marijuana, cocaine or other simular drugs? No Yes - describe _____

Do you exercise? No Yes Type: _____ Freq hrs/week: _____

PHYSICIAN NOTES: _____

