Pacific In Vitro Fertilization Institute Date: _____ Patient Name: _____
DOB: Month _____ Day_____ Year _____
Partner Name: _____

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)

____ Blood Transfusion (date____/____/____)
____ Hepatitis (date____/____/____)
____ Heart Disease (date ____/____/____)
____ Cancer _____
____ Chickenpox (date ____/____/____)
____ Hernia (date ____/____/____)
____ Chlamydia (date ____/____/____)
____ Testes Injury (date ____/____/____)
____ Herpes (date ____/____/____)
____ Measles/Rubella (date ____/____/____)
____ Gonorrhea (date ____/____/____)
____ Frequent Saunas/Steam baths
____ Neurological Problems
____ TB
____ Other_____

____ Bladder Problems
____ High Blood Pressure
____ Kidney Infection
____ Testes Infection
____ Liver Problems
____ Loss of Balance
____ Testes Tumor
____ Thyroid Problems
____ Multiple Sclerosis
____ Mumps after Puberty
____ Fever in last 3 months
____ Genital Warts/HPV
____ Ejaculation Difficulty:
___Premature
___Retrograde

____ Prostatitis
____ Seizures
____ Diabetes
____ Syphilis
____ HIV/AIDS
____ Epilepsy
____ Testicular Pain
____ Scrotal Pain
____ Erection Difficulty
____ Penis Pain
____ Penis Discharge

Exposure at work to:
___ Chemicals
___ Prolonged Heat
___ Radiation
___ Toxic Fumes

FERTILITY TESTING AND TREATMENT

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

____ Clomiphene citrate (Serophene, Clomid)
____ hMG (Pergonal)
____ Tamoxifen
____ Testolactone
____ Testosterone or Male Hormone
____ GnRH or LHRH (Factrel)
____ Fluoxymesterone (Halotestin)
____ hCG (Profasi, A.P.L.)
____ Bromocriptine (Parlodel)
____ Urofollitropin or FSH (Metrodin)
____ Other – Specify _____

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

____ Testicular Biopsy Date: ____/____/____ Physician: _____
____ X-Ray or Ultrasound Date: ____/____/____ Physician: _____
____ Hormonal Test Date: ____/____/____ Physician: _____
Results: FSH _____ LH _____ PRL _____ Testosterone _____

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

____ 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: Month _____ Day_____ Year _____
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:_____
_____
_____
_____