South Jersey Fertility Center

Male Health History Form – Fertility

9/2018

Name:
Date of Birth:
Nickname or Name you like to be called:
Name of Partner:
Occupation:

Fertility History:

Are you the biological parent of a child from this or a prior relationship? [ ] Yes [ ] No

Have you attempted to conceive a pregnancy in a previous relationship? [ ] Yes [ ] No

How long have you been in this current relationship? _____

Have you fathered any pregnancies in a previous relationship? [ ] Yes [ ] No

Have you seen a Urologist for fertility evaluation? [ ] Yes [ ] No

Name of Urologist: _____

Did you receive treatment from a Urologist? [ ] Yes [ ] No

Have you had a semen analysis? [ ] Yes [ ] No

If so, what was the result? _____

Do you suffer any erectile/ejaculatory difficulties? [ ] Yes [ ] No

Did you have the mumps after puberty? [ ] Yes [ ] No

Have you ever had a sexually transmitted disease (ex: gonorrhea, chlamydia, syphilis, herpes, trichomonas)?

If yes, please specify: _____

Have you suffered significant trauma to your testicles? [ ] Yes [ ] No

Social History:

Current smoking status: [ ] Current smoker [ ] Current every day smoker

[ ] Current some day smoker [ ] Smoker [ ] Former smoker

[ ] Current status unknown [ ] Nonsmoker [ ] Unknown if ever smoked

How many cigarettes a day do you smoke? _____

Name:

Are you interested in quitting?

[ ] Ready to quit [ ] Thinking about quitting [ ] Not ready to quit

Alcohol:

How often do you consume alcohol, including beer and wine, in a week:

[ ] Never consumed alcohol (If no, skip other alcohol questions)

[ ] 1-2 times [ ] 3-5 times [ ] >5 times [ ] Socially [ ] Rarely

Did you have a drink containing alcohol in the past year? [ ] Yes [ ] No

How often did you have a drink containing alcohol in the past year?

[ ] Never [ ] Monthly or less [ ] 2-4 times a month [ ] 2-3 times a week

[ ] 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[ ] 1-2 drinks [ ] 3-4 drinks [ ] 5-6 drinks [ ] 7-9 drinks [ ] 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

[ ] Never [ ] Less than monthly [ ] Monthly [ ] Weekly [ ] Daily or almost daily

Drugs:

Have you used drugs other than those for medical reasons in the past year? [ ] Y [ ] N

If yes, please specify: _____

Have you used anabolic (body building) steroids? [ ] Y [ ] N

Do you have exposure to toxic chemicals or radiation? [ ] Y [ ] N

Medical History:

List any medical diagnosis you have (ex: thyroid disorder, high blood pressure, diabetes, depression, history of hepatitis):

List any surgeries that you have had, particularly of the testicles, prostate, or groin area and other surgeries such as of the appendix, gallbladder, spine, etc: _____

_____

List your medications and their doses (if more than 5, please list them in the area below):

Medication	Dosage	Directions

Additional Medication(s): _____

Name:

1. List any allergies to medications and your reactions:

_____

2. What is your blood type? (Please list “unknown” if you are unsure): _____

Name: