

**PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)
MALE PATIENT HISTORY: INFERTILITY**

I. Identifying Information

Date: _____

Name: _____ Partner's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. Day () _____ Evening/Cell () _____

Referring Physician: Name _____

Address _____

Age: _____ Date of Birth: _____ Partner's Age _____ Date of Birth: _____

Race: (check one) Caucasian African/American Asian Hispanic
 Jewish Mediterranean Other

II. Fertility History

How long have you and your present partner been trying to conceive: _____

Have you ever been infertile with a past partner: Yes No If so, how long: _____

Have you ever fathered a pregnancy before (including miscarriages/abortions/other partners): Yes No

If yes, explain: _____

Have you had any of the following tests performed: (Check all that apply and results)

	Date	Results
<input type="checkbox"/> Semen Analysis	_____	_____
<input type="checkbox"/> Anti sperm Antibodies	_____	_____
<input type="checkbox"/> Gonorrhea/Chlamydia Cultures	_____	_____
<input type="checkbox"/> Hormone Tests	_____	_____
<input type="checkbox"/> Urological Exam	_____	_____

III. Medical History

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

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Abnormal Puberty | <input type="checkbox"/> Diabetes <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallbladder Problems <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Disease <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis <input type="checkbox"/> Rubella (German measles) |

- Blood Transfusions High Blood Pressure Scarlet Fever
- Cancer/Type _____ HIV Seizures
- Chicken Pox Kidney Infections Thyroid Problems
- Chronic Headaches Migraine Headaches Ulcers
- Colitis Mumps Vision Problems
- Hernia Repair Undescended testicle (s)

Current Medications: _____

Are you allergic to any medications: Yes No What: _____

Have you ever had surgery before: Yes No Date & type _____

Have you ever had injury to your genitals? Yes No Specify: _____

Do you have difficulty with erection ejaculation or decreased libido (sexual desire) ?

How often do you have vaginal intercourse (sex) with your partner each week? _____

Have you ever had any of the following: (Check all that apply)

- Gonorrhea Genital Herpes Exposure to Radiation
- Chlamydia Syphilis Prolonged Exposure to Chemicals
- Venereal Warts Prostatitis

IV. Social History

Current or Recent Employer / Position _____

Do you drink alcohol: Yes No Number of drinks per week: _____

Do you smoke: Yes No Number of cigarettes per day _____ Number of years smoking: _____

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc) Yes No
If yes, please specify: _____

Do you have a special exercise program: Yes No
If yes, type: _____

Are you on a special diet: Yes No

V. Review of Systems

What is your height? _____ Current weight: _____ Ideal weight: _____

Have you had more than a 10 pound weight gain / loss this past year: ___ Yes ___ No

If so how much: _____ Was this intentional: ___ Yes ___ No

What is your blood type (if known) _____

VI. Family History

Any history of breast cancer, ovarian or colon cancer: ___ Yes ___ No

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you: ___ Yes ___ No

Do any family members have significant health problems or inherited diseases: ___ Yes ___ No

Check all that apply and state relationship to you:

<input type="checkbox"/> Birth defects	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Brain / Spinal defects	<input type="checkbox"/> Fragile X Syndrome	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Cancer (what type)	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tay-Sachs Disease
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Thalassemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease

Who: _____

VII. Additional Health Information

Please bring this form with you to your first appointment. Ensure that records from your current of past physician have been sent or faxed to the address below at least one week in advance of your visit. We look forward to meeting you.

I confirm that all of the above information is true and valid to the best of my knowledge. I also agree that this information or my medical records from this office may be subject to peer review by an outside agency if needed for any credentialing organization.

Signed: _____ Date: _____