



IVF PHOENIX

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date: _____

| | | | |
|------------------------------|-------------------------------|----------------------------------|-------------------------------|
| Name _____ | | Partner's Name _____ | |
| Address _____ | | Address _____ | |
| (_____) _____ | | (_____) _____ | |
| Telephone Number (Day) _____ | | Telephone Number (Evening) _____ | |
| Date of Birth _____ | Partner's Date of Birth _____ | Length of Relationship _____ | Duration of Infertility _____ |
| Insurance Company _____ | | Insurance I.D. # _____ | |

II. TRAVEL/ WORK AND GENERAL BACKGROUND

All present employment- title(s), location, brief description, number of years employed:

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Are you now or have you ever been exposed to any of the following:

| | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Toxic Fumes | <input type="checkbox"/> Other Specify: _____ |
| <input type="checkbox"/> Chemicals | <input type="checkbox"/> Nuclear Radiation | _____ |

III. MEDICAL HISTORY

| Weight | Height | Blood Type (if known) | Yes | No |
|---|----------|-----------------------|--------------------------|--------------------------|
| _____ | _____ | _____ | | |
| Have you lost more than 20 pounds in the last year? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you follow a particular food diet or have any special dietary habits?..... | | | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify: _____ | | | | |
| List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began: | | | | |
| Exercise | Hrs/Week | Age | | |
| _____ | _____ | _____ | | |
| Do you frequently take saunas or steam baths? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery in the pelvic area? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify date and type of surgery: _____ | | | | |
| Have you ever received X-rays in the pelvic area for therapy or diagnosis?..... | | | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain: _____ | | | | |

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

| | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cancer? Specify _____ | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Testes Infection |
| _____ | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Testes Injury |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Testes Tumor |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mumps with Testes Involved | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Any Allergies? List _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nongonococcal Urethritis | _____ |

| | Yes | No |
|--|--------------------------|--------------------------|
| Have you ever been treated for cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain therapy: _____ | | |
| Within the last year, have you taken any prescription medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, list all prescriptions and problems for which you were taking them: _____ | | |
| _____ | | |
| Are you taking any over-the-counter medications on a regular basis? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, List all medications and diagnoses: _____ | | |
| _____ | | |
| Have you had a high fever (over 102°F) during the past 3-4 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use or have you ever used (check all that apply): | | |
| <input type="checkbox"/> Alcohol - How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____ | | |
| <input type="checkbox"/> Cigarettes Number of packs per day _____ | | |
| <input type="checkbox"/> Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____ | | |
| _____ | | |

IV. SEXUAL HISTORY

| | | |
|---|--------------------------|--------------------------|
| Are you circumcised? | <input type="checkbox"/> | <input type="checkbox"/> |
| When you were a child, were both testes descended into the scrotum? | <input type="checkbox"/> | <input type="checkbox"/> |
| At what age did you begin shaving regularly or start to grow a beard? _____ | | |
| How many times have you been married? _____ | | |
| Have you ever produced a child with another partner? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, how long did it take to produce a child? _____ When was this (dates)? _____ | | |
| Have you ever <i>tried</i> to produce a child with another partner? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have trouble getting an erection? | <input type="checkbox"/> | <input type="checkbox"/> |
| Maintaining an erection? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have trouble with ejaculations? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, <input type="checkbox"/> Premature ejaculations <input type="checkbox"/> Retrograde ejaculations? | | |
| Do you feel that some of your ejaculate is deposited in the vagina? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you ever have orgasms without ejaculation during masturbation? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any discharge from the penis? | <input type="checkbox"/> | <input type="checkbox"/> |
| How many times per week do you and your partner now have intercourse? | <input type="checkbox"/> | <input type="checkbox"/> |
| How many times do you have intercourse around ovulation? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you noticed a change in your sexual drive recently? | <input type="checkbox"/> | <input type="checkbox"/> |

V. FAMILY HISTORY

| | | |
|--|--------------------------|--------------------------|
| Is there a family history of infertility? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, who (list all members and relationship to you) _____ | | |
| _____ | | |
| Is there a history of hormonal disorders in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, list who (relationship to you) and what type: _____ | | |
| _____ | | |

VI. HISTORY OF FERTILITY THERAPY

| | | |
|---|--|--------------------------|
| Have you been treated for infertility before? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, who was your physician? _____ | | |
| What cause of infertility was diagnosed? _____ | | |
| What drugs have you taken for infertility? Check all that apply: | | |
| <input type="checkbox"/> Clomiphene citrate (Serophene®, Clomid®) | <input type="checkbox"/> hCG (Profasi®, A.P.L.®) | |
| <input type="checkbox"/> hMG (Pergonal®) | <input type="checkbox"/> Fluoxymesterone (Halotestin®) | |
| <input type="checkbox"/> Tamoxifen | <input type="checkbox"/> GnRH or LHRH (Factrel®) | |
| <input type="checkbox"/> Testolactone | <input type="checkbox"/> Urofollitropin or FSH (Metrodin®) | |
| <input type="checkbox"/> Bromocriptine (Parlodel®) | <input type="checkbox"/> Other- Specify _____ | |
| <input type="checkbox"/> Testosterone or male hormone | <input type="checkbox"/> None | |

Yes No

Have you ever had varicocele repair?
If yes, when? _____

Have you ever had vasectomy reversal or repair?
If yes, when? _____

Have you and your partner ever tried artificial insemination?
If yes: using your sperm? Donor sperm?

Have you and your partner ever tried in vitro fertilization?
If yes, when and explain: _____

Which of the following tests have you had performed? Check all that apply and the results if known:

- Semen Analysis When? _____ Results: _____
- Chlamydia Test When? _____ Results: _____
- Mycoplasma Test When? _____ Results: _____
- Antibody Test When? _____ Results: _____
- Hamster Egg Test When? _____ Results: _____
- Chromosome Test When? _____ Results: _____
- Testicular Biopsy When? _____ Results: _____
- X-ray or Ultrasound of Testes When? _____ Results: _____
- Hormonal Tests (FSH, LH, Prolactin, testosterone) When? _____ Results: _____
- Thyroid Tests When? _____ Results: _____
- Other - Specify _____ When? _____ Results: _____

Is your partner currently seeing a doctor for evaluation of infertility?
If yes, specify physician name and location: _____

Does the doctor feel that your partner has an infertility problem?
If yes, what is the diagnosis and how is she being treated? _____

Has she ever had children with another man?
If yes, when? _____