Male Fertility History

Name: Date:

Fertility History

How long have you been trying to conceive with your partner: ___

Have you had any diagnosis relating to fertility: ☐ No ☐ Yes, Describe: ___

Have you had any fertility treatments: ☐ No ☐ Yes

When: ___

What types: ___

With whom: ___

Have you fathered any children: ☐ No ☐ Yes, When: ___

With your current partner: ☐ No ☐ Yes

Have you had a Semen Analysis: ☐ No ☐ Yes, How Many: ___ Date of most recent: ___

The results: ___

Have you been examined by a urologist: ☐ No ☐ Yes

The results: ___

Have you had any microsurgery, or other operations: ☐ No ☐ Yes, For what condition: ___

The results: ___

Have you had any hormonal blood-work evaluations: ☐ No ☐ Yes

The results: ___

Have you had a vasectomy: ☐ No ☐ Yes, Reversal Date: ___ Are Sperm Antibodies Present: ☐ No ☐ Yes

Have you had any other diagnostic procedures: ☐ No ☐ Yes

Which ones: ___

Health History

At what age did you begin puberty: ___

Have you ever suffered a trauma to your reproductive organs: ☐ No ☐ Yes, When: ___

Describe: ___

Have you ever had a kidney infection: ☐ No ☐ Yes, When: ___

Have you ever had a urinary tract or bladder infection: ☐ No ☐ Yes, When: ___

Have you ever had inflammation of the prostate: ☐ No ☐ Yes, When: ___

Have you had any testicular masses or nodules: ☐ No ☐ Yes, Any diagnosis: ___

Have you ever had a hernia: ☐ No ☐ Yes, When: ___ Has it resolved: ___

Do you have a history of undescended testes: ☐ No ☐ Yes, When did it resolve: ___

Have you had the mumps as a child: ☐ No ☐ Yes, When: ___

Was your mother exposed to DES while pregnant with you: ☐ No ☐ Yes

Have you been treated for any sexually transmitted disease: ☐ No ☐ Yes, When: ___

Describe: ___

Have you had any recent illnesses, colds or flus: ☐ No ☐ Yes, When:______________________________

Describe: ______________________________

Have you been diagnosed with any other medical conditions: ☐ No ☐ Yes

Describe: ______________________________

Lifestyle

How is your sexual energy: ☐ Good ☐ Fair ☐ Low

Do you use condoms with spermicidal agents: ☐ No ☐ Yes

Do you have a very stressful job: ☐ No ☐ Yes

Are you frequently exposed to environmental toxins or pollutants: ☐ No ☐ Yes

Describe: ______________________________

Does your job involve sitting at a desk all day: ☐ No ☐ Yes

Do you have a stressful home environment: ☐ No ☐ Yes

Do you use recreational drugs: ☐ No ☐ Yes

Do you smoke cigarettes: ☐ No ☐ Yes

Do you drink alcohol: ☐ No ☐ Yes, How often: ______________________________

Do you have an exercise routine: ☐ No ☐ Yes, Describe: ______________________________

What do you do for relaxation: ______________________________

Do you have difficulty sleeping: ☐ No ☐ Yes, Describe: ______________________________

Are you overweight: ☐ No ☐ Yes, How many pounds: ______________________________

Are you underweight: ☐ No ☐ Yes, How many pounds: ______________________________

Do you struggle to maintain a consistent weight: ☐ No ☐ Yes, How so: ______________________________

What do you typically eat during the day:

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

Beverages: ______________________________

Medications

Have you recently taken antibiotics: ☐ No ☐ Yes, When: ______________________________

Have you ever taken steroids: ☐ No ☐ Yes, When: ______________________________

Do you take any over the counter medications: ☐ No ☐ Yes

Which ones: ______________________________

Do you take any prescription medications: ☐ No ☐ Yes

Which ones: ______________________________

Do you use any anti-fungal creams or applications: ☐ No ☐ Yes

Do you take any nutritional supplements or herbal products: ☐ No ☐ Yes

Which ones: ______________________________

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Symptoms

Do you ever experience impotence:	☐ No ☐ Yes
Do you ever have painful erections:	☐ No ☐ Yes
Do you have difficulty sustaining an erection:	☐ No ☐ Yes
Do you ever experience nocturnal emissions:	☐ No ☐ Yes
Do you ever experience premature ejaculation:	☐ No ☐ Yes
Do you ever experience difficulty or inability to ejaculate:	☐ No ☐ Yes
Do you ever experience a loss of libido:	☐ No ☐ Yes
Do you ever feel your libido is too high:	☐ No ☐ Yes
Do you experience coldness in your scrotum:	☐ No ☐ Yes
Do you experience swelling in your scrotum:	☐ No ☐ Yes
Do you experience any pain or discomfort in your scrotum, or testes:	☐ No ☐ Yes
Do you ever have a heavy or bearing down sensation in your testicles:	☐ No ☐ Yes
Do you notice any abnormal discharge from your penis:	☐ No ☐ Yes
Do you experience genital itching:	☐ No ☐ Yes
Do you have any genital rashes or sores:	☐ No ☐ Yes
Do you have frequent urination:	☐ No ☐ Yes
Do you have interrupted urine flow:	☐ No ☐ Yes
Do you have scanty urine:	☐ No ☐ Yes
Do you have copious urine:	☐ No ☐ Yes
Is your urine generally light yellow:	☐ No ☐ Yes
Is your urine generally dark yellow:	☐ No ☐ Yes
Does your urine have a strong odor:	☐ No ☐ Yes
Does your urine feel hot:	☐ No ☐ Yes
Do you experience pain with urination:	☐ No ☐ Yes
Do you ever have slight incontinence or dribbling of urine:	☐ No ☐ Yes

Other Comments

Do you have any other additional comments, questions, or concerns at this time: ☐ No ☐ Yes, Describe: ___________________

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