

Fertility History – Male

Name:	Name of Spouse:
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How long have you and your partner been trying to conceive? _____

How would you define your sexual energy?	<input type="checkbox"/> Below Normal	<input type="checkbox"/> Normal
Have you had a recent physical exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you or did you have an undescended testicle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been diagnosed with a varicocele?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any urologic surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced erectile dysfunction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced difficulty ejaculating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had exposure to any known environmental toxins or hormones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced any penile discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you regularly experience nocturnal emissions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have high cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you experienced a high fever in the last six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you currently have any prostate conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have or have you ever had urinary infections or STD's?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever taken testosterone supplements/drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you recently had your testosterone levels checked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been diagnosed with small or soft testes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been checked for a blockage of your reproductive tracts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you had a fertility work-up? Yes _____ No _____			
If yes, what was your sperm count?	<input type="checkbox"/> Below Normal	<input type="checkbox"/> Normal	Number: _____
What was the sperm motility?	<input type="checkbox"/> Below Normal	<input type="checkbox"/> Normal	Notes: _____
What was the sperm morphology?	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal	Notes: _____

Additional Comments:

Please print and complete forms before your initial appointment. Thank you.