

# Men's Fertility History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

How many pregnancies have you and your partner had?

Number	Years
_____	_____

How many children do you have?

_____	_____
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How many abortions have you and your partner had?

_____	_____
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How many miscarriages have you and your partner had?

_____	_____
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Please mark if you have recently experienced any symptoms below.

- Urinary pain    Bloody urine    Penile discharge  
 Penile pain    Genital sores    Testicular pain

Have you ever had any sexually transmitted diseases?    Yes    No

- Chlamydia    Herpes    HIV    Syphilis    HPV  
 Hepatitis B    Hepatitis C    Gonorrhea    Other \_\_\_\_\_

Have you been diagnosed with any defects or obstruction in the reproductive system?    Yes    No

- Cryptorchidism    Anorchism    Variocele    Other \_\_\_\_\_

Have you had any infections of the male reproductive system?

- Orchitis    Prostatitis    Epididymitis    Other \_\_\_\_\_

Have you been diagnosed with any of conditions below?

- Cystic fibrosis    Sickle cell anemia    Hemochromatosis    Diabetes  
 Infections    Kidney disease    High blood pressure    Mumps  
 Impotence    Erectile Dysfunction    Andropause    Hormonal imbalance

Have you had cancer?

- Prostate cancer    Testicular cancer    Other \_\_\_\_\_

**If so, what type of treatments were performed?**

- Chemotherapy**    **Radiation**                       **Surgery**

**Have you had any serious testicular injuries?**     **Yes**     **No**

**If so, please explain.** \_\_\_\_\_

**Have you had any surgeries?**             **Yes**     **No**

- Vasectomy**    **Vasectomy reversal**    **Hernia repair**    **Other** \_\_\_\_\_

**If so, please list dates and any complications.** \_\_\_\_\_

**Are you taking any medications?**     **Yes**     **No**

**If so, please list.** \_\_\_\_\_

**Have you had a fertility workup?**     **Yes**     **No**

**Bloodwork**            **Please list any abnormalities.** \_\_\_\_\_

**Genetic testing**    **Please list any abnormalities.** \_\_\_\_\_

**Semen analysis**

**Morphology** \_\_\_\_\_

**Sperm count** \_\_\_\_\_

**Volume** \_\_\_\_\_

**Mobility** \_\_\_\_\_

**Other** \_\_\_\_\_

**Has your partner had a fertility workup?**                       **Yes**     **No**

**What were the results?** \_\_\_\_\_

**Have you had a diagnosis relating to infertility?**     **Yes**     **No**

**What was it?** \_\_\_\_\_

**Have you and your partner had fertility treatments?**                       **Yes**     **No**

**Medications** \_\_\_\_\_

**Assisted Reproductive Treatments**

**Type of treatments:** \_\_\_\_\_

**Performed by:** \_\_\_\_\_

**Supplements** \_\_\_\_\_

**Hormones** \_\_\_\_\_

**Acupuncture**

**Do you have a single partner with whom you have been trying to conceive?**

**Yes**    **No**

**How long have you been married or living together?** \_\_\_\_\_

**How do feel about starting a family?** \_\_\_\_\_

**Is your partner supportive of your wish to conceive?**    **Yes**    **No**

**What type of birth control have you and your partner used in the past year?**

**Please list.** \_\_\_\_\_

**How long have you been trying to conceive?** \_\_\_\_\_

**How is your sexual energy?**    **Low**             **Normal**     **High**

**Are you more than 20% over your ideal body weight?**    **Yes**    **No**

**Are you more than 20% below your ideal body weight?**    **Yes**    **No**

**Do you have a stressful occupation?**    **Yes**             **No**

**Do you exercise regularly?**    **Yes**    **No**

**Diet:**

**How much water do you drink daily?** \_\_\_\_\_

**How many cups or servings of vegetables daily?** \_\_\_\_\_ **Fruits?** \_\_\_\_\_

**Protein?** \_\_\_\_\_ **Fast food?** \_\_\_\_\_ **Grains?** \_\_\_\_\_

**Oils?** \_\_\_\_\_ **Sugar?** \_\_\_\_\_ **Legumes?** \_\_\_\_\_

**Do you use any chemical substances regularly?**    **Yes**     **No**

<input type="checkbox"/> <b>Caffeine</b>	<b>Cups/day?</b> _____
<input type="checkbox"/> <b>Tobacco</b>	<b>Packs/week?</b> _____
<input type="checkbox"/> <b>Marijuana</b>	<b>Joints/week?</b> _____
<input type="checkbox"/> <b>Alcohol</b>	<b>Drinks/week?</b> _____
<input type="checkbox"/> <b>Other</b>	<b>Quantity/week?</b> _____

**Have you been exposed to any known environmental toxins or hormones?**

**Yes**    **No**

**Additional Comments:**

