



Diamond Institute for Infertility & Menopause
89 Millburn Avenue° Millburn, NJ 07041

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

DATE _____

NAME _____ PARTNER'S NAME _____

ADDRESS _____

TELEPHONE NUMBER -DAY _____ EVENING _____

D.O.B. _____ PARTNER'S D.O.B. _____ DURATION OF RELATIONSHIP _____ DURATION OF INFERTILITY _____

INSURANCE COMPANY _____ INSURANCE ID# _____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment – title(s), location, brief description, number of years employed.

Are you or have you ever been exposed to any of the following during employment or military service:

Heat Toxic Fumes Other Specify _____

Chemicals Nuclear Radiation _____

III. MEDICAL HISTORY

YES NO

WEIGHT _____ HEIGHT _____ BLOOD TYPE IF KNOWN _____

HAVE YOU LOST GREATER THAN 20 POUNDS OF WEIGHT IN THE LAST YEAR?.....

DO YOU FOLLOW A PARTICULAR FOOD DIET OR HAVE ANY SPECIAL DIETARY HABITS?.....

IF YES, SPECIFY: _____

LIST THE FORMS & FREQUENCY OF REGULAR VIGOROUS EXERCISE (SWIMMING, CYCLING, RUNNING & AGE YOU BEGAN:

EXERCISE: _____ HRS/WK AGE EXERCISE; _____ HRS/WK AGE _____

DO YOU FREQUENTLY TAKE SAUNAS OR STEAM BATHS.....

HAVE YOU EVERY HAD SURGERY IN THE PELVIC AREA ?.....

IF YES, SPECIFY DATE & TYPE _____

HAVE YOU EVER RECEIVED X-RAYS IN THE PELVIC AREA FOR THERAPY OR DIAGNOSIS?.....

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 Transfusions | <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 |

- Chronic Headaches
- Colitis
- Diabetes
- Dizziness

- Measles: Regular
- Mumps
- Mumps with Testes Involved
- Neurological Problems
- Nongonococcal Urethritis

- Tuberculosis
- Ulcers
- Visual Disturbances

Any Allergies _____

	YES	NO
HAVE YOU EVER BEEN TREATED FOR CANCER?..... IF YES, EXPLAIN THERAPY _____	<input type="checkbox"/>	<input type="checkbox"/>
WITHIN THE LAST YEAR, HAVE YOU TAKEN ANY PRESCRIPTION MEDICATIONS?..... IF YES, LIST ALL PRESCRIPTIONS AND PROBLEMS FOR WHICH YOU WERE TAKING THEM _____	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU TAKING ANY OVER-THE-COUNTER MEDICATIONS ON A REGULAR BASIS?..... IF YES, LIST ALL MEDICATIONS AND DIAGNOSES: _____	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD A HIGH FEVER (OVER 102°) DURING THE PAST 3-4 MONTHS?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU OR HAVE YOU EVER USED (CHECK ALL THAT APPLY):		
<input type="checkbox"/> ALCOHOL – HOW MANY GLASSES PER WK DO YOU USUALLY DRINK? WINE _____ BEER _____ COCKTAIL _____		
<input type="checkbox"/> CIGARETTES -# PACKS PER DAY _____		
<input type="checkbox"/> ILLICIT OR RECREATIONAL DRUGS (MARIJUANA, COCAINE, ETC.)		

	YES	NO
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?.....	<input type="checkbox"/>	<input type="checkbox"/>
HOW MANY TIMES HAVE YOU BEEN MARRIED? _____		
HAVE YOU EVER PRODUCED A CHILD WITH ANOTHER PARTNER? IF YES HOW LONG DID IT TAKE TO PRODUCE A CHILD? _____ WHEN WAS THIS (DATES) _____	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER TRIED 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?..... IF YES, <input type="checkbox"/> PREMATURE EJACULATIONS <input type="checkbox"/> RETROGRADE EJACULATIONS	<input type="checkbox"/>	<input type="checkbox"/>
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 HAVE SEXUAL INTERCOURSE? _____		
HOW MANY TIMES DO YOU HAVE INTERCOURSE AROUND OVULATION? _____		
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?.....
 IF YES, WHO LIST ALL MEMBERS AND RELATIONSHIPS TO YOU _____

IS THERE HISTORY OF HORMONAL DISORDERS IN YOUR FAMILY?.....
 IF YES WHAT TYPE: _____

VI. HISTORY OF FERTILITY THERAPY

HAVE YOU BEEN TREATED FOR INFERTILITY BEFORE?.....
 IF YES, HOW 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 (SEPOPHENE [®] , COMID [®]) | <input type="checkbox"/> hCG (PROFAST [®] , A.P.I. [®]) |
| <input type="checkbox"/> hMG (PERGONAL [®]) | <input type="checkbox"/> FLUXYMESTERONE (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 SPECIFY DATES _____

HAVE YOU EVER HAD VASECTOMY REVERSAL OR REPAIR?.....
 IF YES SPECIFY DATES _____

HAVE YOU AND YOUR PARTNER EVER TRIED ARTIFICIAL INSEMINATION?.....
 IF YES, USING YOUR SPERM OR DONOR SPERM? _____

HAVE YOU AND YOUR PARTNER EVER TRIED IN VITRO FERTILIZATION...?.....
 IF YES, SPECIFY WHEN AND EXPLAIN: _____

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD PERFORMED? CHECK ALL THAT APPLY AND THE RESULTS IF KNOWN:

- | | | |
|---|-------------|---------------|
| <input type="checkbox"/> SEMEN ANALYSIS | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> CHLAMYDIA TEST | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> MYCOPLASMA TEST | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> ANTIBODY TEST | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> HAMSTER EGG TEST | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> CHROMOSOME TEST | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> TESTICULAR BIOPSY | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> X-RAY OR ULTRASOUND OF TESTES | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> HORMONAL TEST (FSH, LH, PROLACTIN, TESTOSTERONE) | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> THYROID TESTS | WHEN? _____ | RESULTS _____ |
| <input type="checkbox"/> OTHER - SPECIFY _____ | WHEN? _____ | RESULTS _____ |

IS YOUR PARTNER 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 HE BEING TREATED? _____

HAS SHE EVER HAD A CHILD WITH ANOTHER MAN?.....
 IF YES, WHEN _____

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VII. PHYSICAL FINDINGS

VII. SURGERY

IX. OTHER COMMENTS

X. COURSE OF ACTION
