Sincera
REPRODUCTIVE MEDICINE

Male Patient Health History Form

Name ____ Date ________________

Date of Birth_______________ Age__________

Have you fathered any pregnancies? If so, complete the table below.

Pregnancy History						
Pregnancy #	Year	Was this pregnancy a live birth?	How long did it take you to conceive?	Was any infertility treatment required to conceive?	Was this pregnancy with your current partner?	Were there any complications?
1						
2						
3						
4						
5						

Do you currently or have you previously had any difficulties with erection or ejaculation? Y N

Personal Health History		
List any medical problems that you have ever been diagnosed with: (diabetes, high blood pressure, thyroid disorders, psychological/psychiatric disorders, etc.)		
Start Date	End Date	Condition

Have you ever had a sexually transmitted disease? Y N

(Chlamydia, gonorrhea, HPV or genital warts, trichomonas, herpes, syphilis)

Start Date___________ End Date___________ Condition___________

Surgical History		
List all surgeries (include any hernia surgery, pelvic surgery or injury to the groin)		
Date	Surgery	Hospital

Medications		
List all current prescribed medications and over-the-counter drugs including vitamins, herbal supplements, and anabolic steroids you take on a daily basis.		
Date Started	Name of Medication	Dose/Frequency

Allergies		
List all allergies to medications, environment or food.		
Date Occured	Allergy	Reaction

What is your current height? ________ What is your current weight? _________

Have you ever smoked cigarettes? ________ Number of packs/day __________

Age started _________ Stop date (if applicable) _________

Do you drink alcohol? __________ Number of drinks/day __________

Do you use recreational drugs (marijuana, cocaine, etc)?

Last used ________

What is your occupation? ____

Do you have any exposures to toxins, radiation, or other harmful substances? Y N

If so, please describe: ____

Do you have a urologist? Y N

If so, please list name and address: _______________________________________

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Have you ever had a semen analysis? Y N

If so, please list results below.

Semen Analysis Results				
Date/Location	Volume	Concentration	% Motile	Morphology (% nl)

Genetics and Family History:
(If you are unsure about your family history please speak with family members)

Have you or anyone in your family ever had the following conditions:

Down syndrome: Y N Cystic fibrosis: Y N Other chromosome abnormality: Y N

Huntington disease: Y N Mental retardation or learning difficulty: Y N

Muscular dystrophy: Y N Autism: Y N Short stature/dwarfisma: Y N

Spina bifida (opening in the spine): Y N Marfan syndrome: Y N

Anencephaly (opening in head/brain): Y N Sickle cell disease: Y N

Heart defect at birth: Y N Thalassemia: Y N Cleft lip and/or cleft palate: Y N

Hemophilia: Y N Stillbirth: Y N Cancer before age 50: Y N

2 or more pregnancy losses: Y N Seizure disorder: Y N Blindness: Y N

Kidney problems: Y N Excessive bleeding/clotting: Y N Deafness/hearing loss: Y N

Any birth defect not listed above?____

Any other inherited (genetic) condition?____

Any other serious medical condition or surgery?____________________________________

Any other family history that is of concern to you? __________________________________

Are you adopted? Y N Are you and your partner related to each other? Y N

Please tell us anything else you feel it is important for us to know in order to better understand your care:

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