Male Patient History	***Name Last, First:***	***Date of Birth:***

1. Fertility History

How long have you and your present partner been trying to conceive?

Have you ever been infertile with a past partner Y ☐ N ☐ If yes, how long?

Have you ever fathered a pregnancy before Y ☐ N ☐

Have you had any of the following tests performed (Check all that apply)

Test	Date	Result
Semen Analysis ☐		
Antisperm ☐		
Fertility ☐		
Hormone Tests ☐		
Urological exam ☐		
Fertility or Hormonal treatment ☐		

2. Medical History

Do you have or have you ever had (Check all that apply

Abnormal Puberty ☐	Diabetes ☐	Neurological Problems ☐
Anemia ☐	Gallbladder Problems ☐	Pneumonia ☐
Appendicitis ☐	Heart Disease ☐	Rheumatic Fever ☐
Arthritis ☐	Hepatitis ☐	Rubella (German Measles) ☐
Blood Transfusions ☐	High Blood Pressure ☐	Scarlet Fever ☐
Cancer ☐	HIV ☐	Seizures ☐
Chronic Headaches ☐	Liver Problems ☐	Thyroid Problems ☐
Colitis ☐	Migraine Headaches ☐	Tuberculosis (TB) ☐
Mumps ☐	Kidney Infections ☐	Ulcers ☐
		Vision Problems ☐

Are you allergic to any medications, if yes, what:

Have you ever had surgery before Y ☐ N ☐ Date and Type:

Have you ever had an injury to your genitals Y ☐ N ☐ Specify:

Have you ever had any of the following (Check all that apply)

Gonorrhea ☐	Genital Herpes ☐	Exposure to Radiation ☐
Chlamydia ☐	Syphilis ☐	Prolonged exposure to chemicals ☐
Venereal Warts ☐	Prostatitis ☐	Testosterone use ☐

3. Social History

Current or recent employer and position?

Do you drink alcohol Y ☐ N ☐ if yes, how many per week?

Do you smoke Y ☐ N ☐ if yes, number of cigarettes per day? For how long?

Do you now or have you ever used illicit drugs Y ☐ N ☐ if yes, specify:

Do you have an exercise program Y ☐ N ☐ if yes, Type: Numbers per week?

Are you on a special diet? Y ☐ N ☐ if yes, specify:

4. Review of Systems

What is your height: Current Weight: Ideal weight:

Have you had more than a 10-pound gain/loss this pass year Y ☐ N ☐ How much?

What is your blood type, if known?		
5. Family History		
Do any family members have significant health problems or inherited diseases? Y ☐ N ☐		
Check all that apply:		
Birth Defects ☐	Down Syndrome ☐	Muscular Dystrophy ☐
Brain/Spinal Defects ☐	Fragile X Syndrome ☐	Sickle Cell Disease ☐
Cancer ☐	Heart Disease ☐	Tay-Sachs Disease ☐
Cystic Fibrosis ☐	Hemophilia ☐	Thalassemia ☐
Diabetes ☐	High Blood Pressure ☐	Thyroid Disease ☐
Other Genetic Conditions ☐		
6. Medications and Testosterone Use		
What medications are you taking daily?		
Have you taken Testosterone? Y ☐ N ☐		
IF yes, oral or intermuscular injection please indicate:		
How long: Last dose:		