

**HEARTLAND CENTER FOR REPRODUCTIVE MEDICINE
ENDOCRINOLOGY - FERTILITY
MALE**

PERSONAL DATA

SSN# _____
Name _____ Age _____ Date of birth _____
Address _____ Home phone _____
_____ Cell phone _____
Employer _____ Work phone _____
Race _____ Hispanic Yes No Height _____ Weight _____ Education level _____

OCCUPATION/HABITS

Current Occupation _____ Hours worked _____

Past Occupations (list most recent first): _____

If you have any exposures to substances or chemicals please specify: _____

Current nicotine usage: _____ If no, have you smoked previously? _____

Smoker for how long? _____ (years) Cigarette per day? _____ Cigars per day? _____ Smokeless tobacco _____

Caffeine usage: _____ Type _____ Average daily caffeine consumption _____

Alcohol use: _____ Type _____ Average weekly alcohol consumption _____

Current drugs or medications, including vitamins and nonprescription medications:

_____ Stimulants _____ Antibiotics _____ Hormones (specify: _____

_____ Tranquilizers _____ Aspirin _____ Other specify: (1) _____

_____ Decongestants _____ Vitamins (2) _____

_____ Narcotics (frequency of use: _____) (3) _____

_____ Marijuana (frequency of use: _____)

Do you exercise regularly? _____ Activity _____ Frequency _____

_____ Hot baths/saunas _____ Other(specify) _____

_____ Bicycling (frequency _____

_____ Long distance driving _____

MARITAL AND SEX HISTORY:

Present marriage: Years _____ Sexual intercourse frequency: Per month _____ Erection: _____

Adequate penetration? _____ Ejaculation (normal or premature) _____

Difficulties _____

Pain or discomfort _____

Marital Problems _____

Previous marriage(s): _____ Number of years _____ Number of natural children _____ Number of adopted children _____

PAST INFERTILITY TREATMENT OR TESTING:

Please list tests performed, dates, results and name of physician: _____

MEDICAL HISTORY

Have you had any of the following illnesses? (Check box for yes)

Varicocele	Fever (≥ 101 in past 3months)	Prolonged fever	Injuries
Inguinal hernia	Urogenital tuberculosis	Syphilis	Orchitis
Kidney disease	Undescended testicle	Gonorrhea/chlamydia	Epididymitis
Urethritis	Congenital disease, defect or mark	Diabetes	Prostatitis
Hydrocele	Mumps w/testicular involvement. Age	Hypertension	

Was your mother taking any medications or hormones during her pregnancy with you? _____

If you answered yes to any of the above questions please elaborate. Include dates of hospitalization, etc.:

FAMILY HISTORY

Have there been any of the following diseases in your family?

Diabetes	Down's syndrome	Recurrent miscarriages	Hypertension
Heart disease	Spina Bifida	Children w/birth defects	Schizophrenia or depressive psychosis
Kidney disease	Early deaths	Deafness	Infertility
Tuberculosis	Cleft lip or palate	Mental retardation	Other congenital anomalies
Cancer	Limb deformities	Muscular dystrophy	
Cystic fibrosis	Blindness	Sickle cell disease	

If the answer to any of the above is yes, please elaborate: _____

Is there anything else you would like to add to what we have asked? _____
