

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

PERSONAL DATA

Name _____ Age _____ Date of birth _____
Address _____ Home phone _____
_____ Cell phone _____
Employer _____ Work phone _____
Race _____ Ethnic Background _____ 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? _____

