USC Fertility
Alternatives for Today & Tomorrow

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MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____

Nature of present employment (title, brief description) _____

_____

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 _____

II. 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, please specify: _____		

List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and age you began:

Exercise: _____ Hrs/Wk: _____ Age: _____ Exercise: _____ Hrs/Wk: _____ Age: _____

Do you frequently take saunas or steam baths?	☐	☐
Have you ever had surgery in the pelvic area?	☐	☐
If yes, please specify date and type of surgery: _____		
Have you ever received x-rays in the pelvic area for therapy or diagnosis?	☐	☐
If yes, please explain: _____		

Do you have or have you ever had (check all that apply):

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood Transfusions
- ☐ Breast Milky Discharge
- ☐ Breast Soreness
- ☐ Breast Tenderness
- ☐ Cancer / Specify _____ _____
- ☐ Chlamydia
- ☐ Chronic Bronchitis
- ☐ Chronic Headaches
- ☐ Colitis
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gallbladder Problems
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Immunization: German Measles
- ☐ Kidney Infection
- ☐ Liver Problems
- ☐ Loss of Balance
- ☐ Measles: German
- ☐ Measles: Regular
- ☐ Mumps
- ☐ Mumps with testes involved
- ☐ Neurological Problems
- ☐ Nongonococcal Urethritis
- ☐ Parasitic Infection
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Syphilis
- ☐ Testes Infection
- ☐ Testes Injury
- ☐ Testes Tumor
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Visual Disturbances
- ☐ Any Allergies: List _____ _____ _____

Have you ever been treated for cancer?	☐	☐
If yes, explain therapy: _____		

MALE PATIENT HISTORY / PAGE TWO

	YES	NO
Within the last year, have you taken any prescription medications?	☐	☐
If yes, list all prescriptions and problems for which you were taking them: _____		
Are you taking any over-the-counter medications?	☐	☐
If yes, please list all prescriptions and problems for which you were taking them: _____		
Have you had a high fever (over 102ºF) during the past 3-4 months?	☐	☐

Do you use or have you ever used (check all that apply):

☐ Alcohol – How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____

☐ Cigarettes – Number of packs per day _____

☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss directly with your physician. _____

III. SEXUAL HISTORY

	YES	NO
Are you circumcised?	☐	☐
When you were a child, were both testes descended into the scrotum?	☐	☐
At what age did you begin shaving regularly or start to grow a beard?	☐	☐
How many times have you been married? _____		
Have you ever produced a child with current partner? _____ with another / past partner? _____	☐	☐
If yes, how long did it take to produce a child? _____ When was this? (dates) _____		
Have you ever *tried* to produce a child with another partner?	☐	☐
Do you have trouble getting an erection?	☐	☐
Maintaining an erection?	☐	☐
Do you have trouble with ejaculations?	☐	☐
If yes ☐ premature ejaculation ☐ retrograde ejaculations		
Do you feel that some of your ejaculate is deposited into the vagina?	☐	☐
Do you ever have orgasms without ejaculation during masturbation?	☐	☐
Do you have discharge from the penis?	☐	☐
How many times per week do you and your partner have intercourse? _____		
How many times do you have intercourse around ovulation? _____		
Have you noticed a change in your sexual drive recently?	☐	☐

IV. FAMILY HISTORY

	YES	NO
Is there a family history of infertility?	☐	☐
If yes, who (list all members and relationship to you): _____		
Is there a history of hormonal disorders in your family?	☐	☐
If yes, who and type: _____		

MALE PATIENT HISTORY / PAGE THREE YES NO

VI. HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before? ☐ ☐

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Check all that apply:

- ☐ clomiphene citrate (Clomid®)
- ☐ hMG (Repronex®, Pergonal®)
- ☐ tamoxifen
- ☐ testolactone
- ☐ bromocriptine (Parlodel®)
- ☐ testosterone or Male hormones
- ☐ hCG (Profasi®)
- ☐ fluoxymesterone (Halotestin®)
- ☐ GnRH or LHRH (Factrel®)
- ☐ urofollitropin or FSH (Follistim®)
- ☐ Other – specify _____
- ☐ None

Have you ever had a varicocele repair? ☐ ☐

If yes, please specify dates: _____

Have you ever had a vascectomy reversal or repair? ☐ ☐

If yes, please specify dates: _____

Have you and your partner ever tried artificial / intra-uterine insemination? ☐ ☐

If yes, using ☐ your sperm? ☐ donor sperm?

Have you and your partner ever tried in vitro fertilization? ☐ ☐

If yes, when and explain? _____

Which of the following tests have you had performed? Check all that apply and the results if known:

☐ Semen Analysis When? _____ Results: _____

☐ Chlamydia Test When? _____ Results: _____

☐ Mycoplasma Test When? _____ Results: _____

☐ Antibody Test When? _____ Results: _____

☐ Hamster Egg Test When? _____ Results: _____

☐ Chromosome Test When? _____ Results: _____

☐ Testicular Biopsy When? _____ Results: _____

☐ x-ray or ultrasound of testes When? _____ Results: _____

☐ Hormonal Tests (FSH, LH, prolactin, testosterone) When? _____ Results: _____

☐ Thyroid Tests When? _____ Results: _____

☐ 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 children with another man? ☐ ☐

If yes, when? _____