

MALE PATIENT INFORMATION

Houston Fertility Center
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PERSONAL INFORMATION

Name: _____ DOB: _____ HT: _____ WT: _____

Address: _____

Home: _____; Work Phone: _____ Ethnic Origin: _____

SS#: _____; Married: Yes ____; No ____; Years: _____

Spouse's Name: _____

PERSONAL HABITS & GENERAL INFORMATION

Check all that apply

Alcohol Use: How many glasses per week do you usually drink? Wine ____ Beer ____ Cocktails ____.

Do you smoke? ____ Daily ____ Occasionally ____ Rarely ____ Never. If yes, ____ packs/day; If you did smoke but quit, when did you last smoke? ____; how many pack/day? ____ for how many years? ____.

Illicit or recreational drugs (Marijuana, Cocaine, Etc..)

Have you had testicular or pelvic surgery? Yes No. If yes, specify date and type:

Have you ever been treated for cancer? Yes No. If yes, specify date and type:

HISTORY OF FERTILITY THERAPY (Check all that apply)

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

| <u>Test</u> | <u>When</u> | <u>Results</u> |
|---|-------------|----------------|
| <input type="checkbox"/> Semen Analysis | _____ | _____ |
| <input type="checkbox"/> Chlamydia Test | _____ | _____ |
| <input type="checkbox"/> Hormonal Assays FSH, LH Prolactin, Testosterone | _____ | _____ |
| <input type="checkbox"/> Chromosome Test | _____ | _____ |
| <input type="checkbox"/> Sperm Antibody Test | _____ | _____ |
| <input type="checkbox"/> Testicular Biopsy | _____ | _____ |
| <input type="checkbox"/> Thyroid Tests | _____ | _____ |
| <input type="checkbox"/> X-Ray or ultrasound of Testes | _____ | _____ |
| <input type="checkbox"/> Other – Specify _____ | | |

Have you been treated for infertility before? Yes N

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

Treatment _____

Do you have any knowledge whether you have ever been exposed to any of the following drugs or toxins?

In Utero: Diethylstilbestrol; Antiandrogens. Occupational Exposure: Carbon Disulfide; Lead;
 Estrogens; Chloroquine; Ethylene Glycol. Prescriptions Drugs: Chemotherapeutic Agents;
 Sulfasalazine; Androgens.

LIST ANY SIGNIFICANT FAMILY MEDICAL HISTORY

Self, your parents, siblings, children, aunts, uncles, grandparents, cousins _____

MEDICATIONS

List ALL current medications or treatments (include vitamins, aspirin, antacids, laxatives, etc):

| <u>Medication</u> | <u>How Often</u> | <u>Reason</u> |
|-------------------|------------------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Usual Weight? _____ # lbs recently lost or gained? _____

Have you been tested for HIV? ___ Yes ___ No; If yes, Results _____

Allergies (medicines, food, pollens)? ___ Yes ___ No; if yes, list kind:

CHECK THE APPROPRIATE SPACE FOR
CONDITIONS OCCURING NOW OR IN THE PAST

- | | | |
|--|---|--|
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Allergies. List _____ | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Psychiatric disorders |
| _____ | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pains in Joints |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter, Thyroid | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Bleeding or Bruising | <input type="checkbox"/> Hepatitis, Jaundice | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Cancer Specify? _____ | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Syphilis |
| _____ | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Testes Infection |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Lymph Node | <input type="checkbox"/> Testes injury |
| <input type="checkbox"/> Chest Pain, Pressure | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Testes injury |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Convulsions, Seizures | <input type="checkbox"/> Murmurs | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Urinating |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Wheezing, Asthma |
| <input type="checkbox"/> Dizziness, Fainting | <input type="checkbox"/> Prostate Enlargement | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Prostatitis; Bacterial | |
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