PARTNER NAME: DATE OF BIRTH: FEMALE PATIENT NAME:

New York Reproductive Wellness
Male Medical History & Information

MEDICAL HISTORY

Please list all medical problems.

Examples: diabetes, high blood pressure, liver disease/ infection, prostate or urinary tract infections, cancer (if yes, what type), neurological problems, multiple sclerosis.

Medical problem	When diagnosed; doctor taking care of you; treatment received
1. ____________________	____
	____
2. ____________________	____
	____
3. ____________________	____
	____
4. ____________________	____
	____

-Have you had a semen analysis? Y N Were the results abnormal? Y N
Semen analysis results, if known (concentration, motility, morphology): ________
____
-Do you have retrograde ejaculation (sperm into the bladder)? Y N
-Have you ever had any of the following infections (circle all that apply)?
Herpes/ Genital warts/ Syphilis/ HIV or AIDS/ Hepatitis/ Chlamydia/ Gonorrhea/ Mumps infection after puberty

SURGICAL HISTORY

Please provide a list of previous surgical procedures (e.g. hernia, varicocele surgery, vasectomy or vasectomy reversal, surgery to correct an undescended testicle(s), bladder or penis surgery):

PARTNER NAME: DATE OF BIRTH: FEMALE PATIENT NAME:

Date	Procedure	Diagnosis	Doctor	Hospital

1. ____
2. ____
3. ____
4. ____

ALLERGIES

Please list all the medications or substances that you have an allergy to (e.g. penicillin), and the reaction experienced.

1. ____
2. ____

MEDICATIONS

Medication	Dosage of Medication	How many tablets/ day	Doctor

1. ____
2. ____

SOCIAL HISTORY

How many cups of coffee, tea or caffeinated soda do you drink/ day? __________
Do you or have you ever smoked cigarettes (or used any tobacco product)? Y N
If so, how many packs/day and for how many years? ______________________
Do you drink alcoholic drinks (beer, wine, liquor)? Y N If yes, how many glasses/ week? ____
Do you, or have you ever used other drugs (e.g. marijuana, cocaine or other recreational drugs)? Y N Please specify: ____________________________

PARTNER NAME: DATE OF BIRTH: FEMALE PATIENT NAME:

Current occupation: ____
Are you aware of any potentially hazardous environmental exposure at work or home? Y N Please specify: ____

What is your ethnic background (e.g. Ashkenazi Jewish, French Canadian, Italian or other Mediterranean, African American)? ___________________________

How many children, if any, do you have and their ages: ______________________
Do you exercise? Y N If yes, what kind and how often/ week?
____
Do you use hot tubs regularly? Y N

FAMILY HISTORY

Do you have a family or extended family members (include mother, father, sisters, brothers, children, paternal grandparents/ uncles/ aunts, maternal grandparents/ uncles/ aunts) with any of the following?

thyroid disorder, diabetes, high blood pressure, heart disease, stroke, liver disease/ infection, kidney disease, blood clots (e.g. in leg or lung), bleeding disorder, cancers and psychiatric disorders (e.g. depression, schizophrenia, bipolar disorder)?

Family member	Medical conditions
1. ______________________	____
2. ______________________	____
3. ______________________	____
4. ______________________	____
5. ______________________	____
6. ______________________	____

Do you have any family history of any of the following?:
Y N inherited conditions [e.g. Cystic Fibrosis, Muscular Dystrophy, Sickle Cell Anemia, Thalassemia, Huntington's disease, Ashkenazi Jewish diseases (e.g. Tay-Sachs, Gaucher disease, Canavan Disease, Bloom Syndrome, Niemann-Pick disease, Fanconi Anemia, Familial Dysautonomia), Fragile X Syndrome,

Spinal Muscular Atrophy, Hemophilia, Hemochromatosis, Dwarfism, Polycystic kidney disease, Marfan Syndrome, Galactosemia, color blindness, deafness/ blindness)

Y N Down Syndrome, or other chromosomal defects
Y N autism
Y N mental retardation
Y N developmental delay
Y N birth malformations
Y N infertility

Please specify: ____

SIGNS & SYMPTOMS

Do you have any of the following? Please elaborate:

Y N abnormal vision ____
Y N blood in urine or stool ____
Y N decreased libido ____
Y N discharge from the penis ____
Y N fevers in the last 3 months ____
Y N headaches ____
Y N mass or lump in the testicle(s) ____
Y N pain in the penis or testicles ____
Y N problems with ejaculation or erections ______________________________
Y N skin discoloration or lesions on the genitals ______________________________

I confirm that I have read this form and that the information provided by me is true to the best of my knowledge.

Spouse/Male Partner's Signature: ____________________
Date: ____________________