

MALE INFORMATION

Name: _____	Birth date: _____	Age: _____
Occupation: _____	Race: _____	
Height: _____ ft _____ inches	Weight: _____ pounds	
Recent changes in weight? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever been involved in a pregnancy? Yes No
 If yes, how many times (regardless of outcome or delivery)? _____

If yes, answer for each pregnancy **outside of this relationship**.

Date (Mo/Yr)	Gender	Current Partner?	Months to Conception	Difficulty Conceiving?	Fertility Treatment?	Outcome	Delivery Type
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment? _____	<input type="checkbox"/> Term <input type="checkbox"/> Pre-Term <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Living	<input type="checkbox"/> Vaginal Delivery <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____ _____
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment? _____	<input type="checkbox"/> Term <input type="checkbox"/> Pre-Term <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Living	<input type="checkbox"/> Vaginal Delivery <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____ _____
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment? _____	<input type="checkbox"/> Term <input type="checkbox"/> Pre-Term <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Living	<input type="checkbox"/> Vaginal Delivery <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____ _____
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment? _____	<input type="checkbox"/> Term <input type="checkbox"/> Pre-Term <input type="checkbox"/> Ectopic <input type="checkbox"/> Abortion <input type="checkbox"/> Miscarriage <input type="checkbox"/> Living	<input type="checkbox"/> Vaginal Delivery <input type="checkbox"/> C-Section <input type="checkbox"/> Other: _____ _____

Please check here, if you have been involved in than four pregnancies outside this relationship.

MEDICAL HISTORY

Do you have long-standing medical conditions? Yes No
 If yes, please list:

	Medical Condition	Comments/Findings
1		
2		
3		
4		
5		

Please check here, if you have more than five medical conditions.

Are you currently taking any medication? Yes No
 If yes, please list:

	Medications	Reason / Comments
1		
2		
3		
4		
5		

Please check here, if you are taking more than five medications.

Do you use herbal remedies or medications? Yes No
 If yes, how much per day? _____

Have you had any surgeries? Yes No
 If yes, please list:

	(Mo/Yr)	Indication	Surgery	Findings	Complications
1	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
2	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
3	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
4	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No
5	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check here, if you have had more than five surgeries.

Have you had any exposure to or have been treated for any sexually transmitted disease or infection? Yes No

If yes, please list:

	Infection	Result / Comments
1		
2		
3		
4		
5		

Please check here, if you have had exposure or have been treated for more than five sexually transmitted infections.

Are you allergic to or have had any adverse reaction to any drugs? Yes No

If yes, please list:

	Medications	Reaction / Comments
1		
2		
3		
4		
5		

Please check here, if you are allergic to or have adverse reaction to more than five medications.

Have you had mumps? Yes No

If yes, at what age? _____

Do you have any difficulty with erections? Yes No

Have you ever been unable to impregnate a female partner? Yes No

Have you ever been a sperm donor? Yes No

Have you ever required hormone treatment(s)? Yes No

Have you ever had vesectomy? Yes No

Have you ever had surgery to testicles? Yes No

Have you had undescended testicles? Yes No

Have you had trauma to the testicles? Yes No

Have you had painful swelling of the testicles? Yes No

Have you had torsion (twisting) of the testicles? Yes No

Have you ever had white blood cells in your semen? Yes No

Have you ever had a prostate infection? Yes No

ENVIRONMENTAL FACTORS

Do you smoke? Yes No

If yes, how much per day? _____ (# of cigarettes/day)

Have you ever smoked?

If yes, how much per day? _____ (# of cigarettes/day) when did you quit? _____ (Mo/Yr)

Do you drink alcohol? Yes No

If yes, how would you describe your drinking habits?

Socially _____ drinks / week

Daily _____ drinks / day

Alcoholic _____ drinks / _____ (how often?)

Do you have or had you had alcohol dependence? Yes No
If yes, when did you quit? _____ (Mo/Yr)

Do you consume caffeinated beverages? Yes No
If yes, how much? 1-2 per day 3-4 per day More than 5 per day

Do you use "recreational" drugs? Yes No
If yes, what? _____

Do you take baths or use hot tubs? Yes No
If yes, how often per week? _____ For how long? _____ minutes.

Have you had a recent high fever? Yes No
If yes, when? _____ (Mo/Yr)

Do you use steroids for body building? Yes No
If yes, which one(s)? _____

Are you exposed to any chemicals? Yes No
If yes, which one(s)? _____

GENETIC / FAMILY HISTORY

Ancestry (Mother) _____

Ancestry (Father) _____

Eastern European /Jewish Ancestry

Have you had Tay Sach's screening tests? Yes No
If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had a Canavan Screening Test? Yes No
If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had Bloom Screening Test? Yes No
If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had Gaucher Screening Test? Yes No
If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had Fanconi anemia Screening Test? Yes No
If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Have you had Neimman-Pick Screening Test? Yes No
If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

African Ancestry

Have you had Sickle cell screening tests? Yes No
If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

European Ancestry or Family member with cystic fibrosis

Have you had Cystic fibrosis screening test? Yes No
If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Italian, Greek, Mediterranean or Southeast Asian ancestry

Have you had screening for inherited forms of anemia such as thalassemia? Yes No
If yes, when? _____ (Mo/Yr). What were the findings? Normal Abnormal: _____

Do you or anyone in your family have any of the following medical conditions? Yes No
If yes, please check all that apply

Medical Condition	Self	Mother	Father	Brother	Sister	Child
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation - Chromosomal Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Retardation - Testing for Fragile X Mutation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects - Chromosomal testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Miscarriage / Pregnancy loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early Puberty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delayed Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short Stature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undescended Testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testicular Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chromosome Disorder (e.g. Down's Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurofibromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marfan Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a birth defect or familial disorder not listed above? Yes No

If yes, Please describe? _____

Have you or your significant other in this or any previous relationship had a stillborn child or more than two first trimester miscarriages?

Yes No

MALE INFERTILITY TESTS

Have you or your past or present female partner(s) ever participated in fertility treatment? Yes No

Have you ever had fertility medications (hormone, etc.)? Yes No

Have you ever been seen by a urologist or male infertility expert? Yes No

If yes, please respond to the following questions:

- Have you had surgery to correct a sperm problem? Yes No
If yes, what type of surgery? _____
- Have you had surgery to correct sperm problem? Yes No
If yes, what type of surgery)? _____
- Have you had an ultrasound of the testicles? Yes No
If yes, when and what was the result? _____
- Have you had blood tests for infertility? Yes No
If yes, when and what was the result? _____
- Have you had sperm chromatin test? Yes No
If yes, when and what was the result? _____
- Have you had sperm chromatin (DNA Fragmentation – SCSA) test? Yes No
- Have you had a semen analysis test? Yes No
If yes, please provide details:

	Date (Mo/Yr)	Location Performed	Abstinence (Days)	Volume	Concentration (millions/ml)	Motility (%)	Morphology (%)	Antibodies
1								<input type="checkbox"/> Yes <input type="checkbox"/> No

2								<input type="checkbox"/> Yes <input type="checkbox"/> No
3								<input type="checkbox"/> Yes <input type="checkbox"/> No
4								<input type="checkbox"/> Yes <input type="checkbox"/> No
5								<input type="checkbox"/> Yes <input type="checkbox"/> No
6								<input type="checkbox"/> Yes <input type="checkbox"/> No
7								<input type="checkbox"/> Yes <input type="checkbox"/> No
8								<input type="checkbox"/> Yes <input type="checkbox"/> No
9								<input type="checkbox"/> Yes <input type="checkbox"/> No
10								<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check here, if you have had more than 10 semen analysis done.

- Have you had a sperm penetration assay? Yes No
If yes, when and what was the result? _____
- Have you had a acrosome reaction test? Yes No
If yes, when and what was the result? _____
- Have you had a chromosome analysis (karyotype) test? Yes No
If yes, when and what was the result? _____
- Have you had an evaluation of Y chromosome deletion? Yes No
If yes, when and what was the result? _____