

THE NEW HOPE CENTER *for* REPRODUCTIVE MEDICINE

1181 First Colonial Rd., Suite 100, Virginia Beach, VA 23454 . Phone: (757) 496-5370 . Fax: (757) 481-3354 . www.thenewhopecenter.com

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Please read all questions carefully and answer as thoroughly as possible.

Date: _____

Name: _____ Partner's Name: _____

Address: _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

Does your home phone have an answering machine? Yes / No May we call you at work? Yes / No

Date of Birth: _____ Age: _____ SS#: _____ Partner's Date of Birth: _____ Age: _____

Duration of Relationship: _____ Duration of Infertility: _____

2. TRAVEL/WORK & GENERAL BACKGROUND

Nature of present employment (please give us your title and a brief description): _____

Are you, or have you ever been, exposed to any of the following during employment or military service:

Heat Toxic Fumes Chemicals Nuclear Radiation

Other (please specify): _____

3. MEDICAL HISTORY

Height: _____ Weight: _____ Blood Type (if known): _____

Have you gained or lost greater than 20 pounds of weight in the past year? Yes / No

Do you follow a particular food diet or have any special dietary habits? Yes / No

If yes, please specify: _____

Do you frequently use saunas, steam baths or whirlpools? Yes / No

Have you ever had surgery in the pelvic area? Yes / No

If yes, please specify date and type of all surgeries: _____

Have you ever received x-rays in the pelvic area for therapy or diagnosis? Yes / No

If yes, please specify: _____

Have you ever been treated for cancer? Yes / No

If yes, please explain therapy: _____

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MALE PATIENT HISTORY (PAGE 2 OF 4)

PATIENT NAME _____ PHONE NUMBER _____

3. MEDICAL HISTORY (continued from page one)

Within the past year, have you taken any prescription medicines? Yes / No

If yes, list all prescriptions and problems for which you were using them: _____

Are you taking any over-the-counter medications regularly? Yes / No

If yes, list medications and conditions for taking them: _____

Have you had a high fever (over 102°F) in the last 3-4 months? Yes / No

Do you use or have you ever used the following? (check all that apply)

Alcohol-How many glasses per week on average? _____ Wine _____ Beer _____ Cocktails

Cigarettes-Number of packs per day _____

Recreational Drugs-(marijuana, cocaine, etc.) current or past _____

List all forms of vigorous exercise (swimming, cycling, running, etc.)

| Exercise | Hours Per Week |
|----------|----------------|
|----------|----------------|

| | |
|-------|-------|
| _____ | _____ |
|-------|-------|

| | |
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| _____ | _____ |
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| | |
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| _____ | _____ |
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| | |
|-------|-------|
| _____ | _____ |
|-------|-------|

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

Allergies-(please list and describe reaction) _____

Anemia

Appendicitis

Arthritis

Blood Transfusions

Breast Milky Discharge

Breast Tenderness

Cancer (specify) _____

Chlamydia

Chronic Bronchitis

Colitis

Color Blindness

Diabetes

Dizziness

Epilepsy

Gallbladder

Gonorrhea

Heart Disease

Hepatitis

Herpes

High Blood Pressure

Kidney Infection

Liver Problems

Loss of Balance

Measles: German

Measles: Regular

Mumps

Mumps: 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

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MALE PATIENT HISTORY (PAGE 3 OF 4)

PATIENT NAME _____ PHONE NUMBER _____

3. SEXUAL HISTORY *(continued from page two)*

- Are you circumcised? Yes / No
- When you were a child, were both testes descended into the scrotum? Yes / No
- At what age did you begin shaving regularly or notice a beard? _____
- How many times have you been married? _____
- Have you ever tried to produce a child with another partner? Yes / No
- Have you produced a child with another partner? Yes / No
- If yes, how long did it take to produce the child? _____
- When was this? (please list dates) _____
- Do you ever have trouble getting an erection? Yes / No
- Do you ever have trouble with ejaculations? Yes / No
- If yes, premature ejaculations retrograde ejaculations
- Do you feel that most of your ejaculate is deposited into the vagina? Yes / No
- Do you ever have orgasms without ejaculation during masturbation? Yes / No
- Do you have any abnormal discharge from the penis? Yes / No
- How many times per week do you and your partner have intercourse? _____
- How many times do you have intercourse around time of ovulation? _____
- Have you noticed a change in your sexual drive recently? Yes / No
- Have you had an injury to/abnormality of the penis testicles or prostate? Yes / No
- If yes, when? _____ Outcome/Result _____

4. FAMILY HISTORY

- Is there a family history of infertility? Yes / No
- If yes, who has had infertility problems? (list all family members and their relationship to you) _____
- Is there a family history of hormonal disorders? Yes / No
- If yes, who has had hormonal disorders, and what type? _____

5. HISTORY OF FERTILITY THERAPY

- Have you ever been treated for infertility before? Yes / No
- If yes, who was your physician? _____
- What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? (please check all that apply)

- | | |
|--|---|
| <input type="radio"/> bromocriptine (Parlodel®) | <input type="radio"/> hMG (Pergonal®) |
| <input type="radio"/> clomiphene citrate (Serophene®, Clomid®) | <input type="radio"/> tamoxifen |
| <input type="radio"/> hCG (Profasi®, A.P.L.®) | <input type="radio"/> testolactone |
| <input type="radio"/> None | <input type="radio"/> testosterone or Male Hormone |
| <input type="radio"/> Other (specify) _____ | <input type="radio"/> urofollitrophin or FSH (Fertinex® or Metrodin®) |

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MALE PATIENT HISTORY (PAGE 4 OF 4)

PATIENT NAME _____ PHONE NUMBER _____

5. HISTORY OF FERTILITY THERAPY *(continued from page three)*

Have you ever had a varicocele repair? Yes / No

If yes, when, and who performed this? _____

Have you ever had a vasectomy reversal or repair? Yes / No

If yes, when, and who performed this? _____

Have you and your partner ever tried invitro fertilization? Yes / No

If yes, when and where? _____

Is your partner currently seeing a doctor for evaluation of infertility? Yes / No

If yes, please list doctor's name and address _____

Does this doctor feel that your partner has an infertility problem? Yes / No

If yes, what is the diagnosis and current treatment? _____

Has your partner ever conceived a child with another partner? Yes / No

Which of the following tests have you had performed? *(please check all that apply)*

Semen Analysis When? _____ Results? _____

ODNA Fragmentation Test When? _____ Results? _____

Chlamydia Test When? _____ Results? _____

Mycoplasma or Ureaplasma Test When? _____ Results? _____

Antibody Test When? _____ Results? _____

Chromosome Test When? _____ Results? _____

Testicular Biopsy When? _____ Results? _____

Xray or Ultrasound of Testes When? _____ Results? _____

Hormonal Assays When? _____ Results? _____

(FSH, LH, prolactin, testosterone)

Thyroid Function Tests When? _____ Results? _____

Other (specify): _____ When? _____ Results? _____

_____ When? _____ Results? _____

_____ When? _____ Results? _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM IN ADVANCE OF YOUR FIRST APPOINTMENT.

Please make sure your name and phone number are listed at the top of each page, and fax it to us at: (757) 481-3354.

If you prefer, you may mail it to:

The New Hope Center for Reproductive Medicine
1181 First Colonial Rd., Suite 100,
Virginia Beach, VA 23454

If you have any questions, please call: (757) 496-5370.