MALE PATIENT HISTORY

Date _____ Name_____
Weight_____ Height _____ Blood Type (if known) _____
Have you fathered a pregnancy prior? (circle) **YES** **NO**
If yes, when and what was/were the outcome(s)? _____
Are you, or have you ever been exposed to any of the following during employment or military service? (If so, please explain)

Heat_____ Toxic fumes_____
Chemicals_____ Nuclear radiation_____
Other_____

Do you frequently take saunas or steam baths? **YES** **NO**

Infertility History:

Have you ever been treated for infertility in the past? **YES** **NO**
If yes, please describe treatment: _____
Have you had a vasectomy? **YES** **NO**
If yes, who performed the procedure? _____
Any history of pelvic infection? **YES** **NO** Pelvic trauma? **YES** **NO** Pelvic surgery? **YES** **NO**
If yes, please explain: _____
Have you ever had a semen analysis? (If yes, who performed the test and what were the results?)
_____

Procedure History:

Please list all types and dates of surgeries you have undergone:_____
_____

Medical History:

Are you currently experiencing any medical problems? (If yes, please describe):_____
_____
Have you ever been treated for cancer? **YES** **NO**
If yes, please explain: _____
What medications do you regularly take? (Prescription and/or over the counter drugs; include dosage)
_____
_____
Allergies? **YES** **NO**
If yes, please list:_____
Family history of blood clotting disorders? **YES** **NO**
Any other medical problems in the family? **YES** **NO**
If yes, please explain? _____

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

Anemia	Diabetes	Liver problems	Rheumatic fever
Appendicitis	Dizziness	Loss of balance	Scarlet fever
Arthritis	Epilepsy	Measles: German	Seizures
Bleeding disorder	Gall bladder problems	Measles: Regular	Syphilis
Blood transfusion	Gonorrhea	Mumps	Testes infection
Chlamydia	Heart disease	Mumps w/testes involved	Testes injury
Chronic bronchitis	Hepatitis	Neurological problems	Testes tumor
Chronic headaches	Herpes	Nongonococcal urethritis	Thyroid problems
Colitis	High blood pressure	Parasitic infection	Tuberculosis
Cystic Fibrosis	Kidney infection	Pneumonia	Visual disturbances
Cancer (specify)_____		Prostatitis	

Do you or have you ever, used:

Alcohol? How many drinks per week?_____
Cigarettes? How many packs per day?_____
Illicit or recreational drugs?_____

Countries of origin:

Mother's family:_____ Father's family:_____

Ethnic background (circle):

African American Asian Asian-Indian Caucasian Hispanic

Jewish American Indian Mediterranean Middle Eastern Other:_____

Ethnic Group: (check all that apply)	**Have you ever been tested for:**	**Yes**	**No**	**Date**	**Result**
African, African/American	Sickle cell trait				
Chinese, Southeast Asian, Mediterranean (Greek or Italian) or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic Fibrosis				
Jewish	Bloom Syndrome				
	Canavan Familial Dysautonomia (FD)				
	Fanconi Anemia (type C)				
	Gaucher Disease (Type I)				
	Glycogen Disease (Type 1a)				
	Maple Syrup Urine Disease				
	Mucolipidosis (Type IV ML IV)				
	Niemann – Pick Type A				
	Spinal Muscular Atrophy (SMA)				
	Tay Sachs				

Other inherited disorders?:_____

Would you like to take the test(s) recommended for your specific ethnic group? (Circle) **YES** **NO**

Are you related to your spouse (consanguinity)? (Circle) **YES** **NO**

Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed?
(Circle) **YES** **NO**