

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: Have you ever been tested for: Yes No Date Result

(check all that apply)

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	_____	_____	_____	_____
	Mucopolipidosis (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**