Today's date_____/_____/_____ Date of appointment_____/_____/_____

MEDICAL AND REPRODUCTIVE HISTORY

PATIENT:
(Legal) Last name:_____ **(Legal)** First name:_____ Middle initial _____

Age: _____Date of Birth: _____/_____/_____ Soc. Security #: _____-_____-_____

Marital Status: _____single _____married _____domestic partner Length of Relationship: _____years

PARTNER:
(Legal) Last name:_____ **(Legal)** First name:_____ Middle initial _____

Age: _____Date of Birth: _____/_____/_____ Soc. Security #: _____-_____-_____

MAILING ADDRESS:
Street:_____ City: _____

State/Providence: _____ Zip/Postal Code: _____ Country: _____

	OK to leave message?		Best # to reach you:
Home Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Patient Work Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Partner Work Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Patient Cell Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐
Partner Cell Phone Number: (_____)_____-_____	☐ Yes	☐ No	☐

Patient Email Address: _____ Partner Email Address: _____

How did you hear about SRM?
- ☐ Family/Friend
- ☐ Internet
- ☐ Radio
- ☐ Medical office/physician referral
  - o Name of office/physician: _____
- ☐ Other _____

Would you like medical notes sent to your other healthcare providers
- ☐ Yes
- ☐ No

If yes, please indicate which provider(s) you would like us to send medical notes to:

Provider Name	Address	Please indicate provider type: Primary care	Urologist	Other

Reason for visit:_____

REPRODUCTIVE HEALTH HISTORY—MALE

List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)? _____ Yes _____ No

Have you ever consulted a urologist or male infertility specialist? _____ Yes _____ No

If yes: Year: _____ Reason: _____

Findings / Recommendations: _____

Have you and/or your partner traveled to a country, territory, or city where there has been active Zika virus transmission in the last 6 months? If so, please specify place(s) and dates. _____

Are you and/or your partner planning travel to a country, territory, or city where there has been active Zika virus transmission? If so, please specify place(s) and dates. _____

PREVIOUS FERTILITY EVALUATION:
Have you had any of the following tests performed?

Fertility Test:	Yes	No	Date	Result normal? Yes	No	If no, describe:
Semen Analysis	☐	☐	___/___/___	☐	☐	_____
Hormone Blood tests	☐	☐	___/___/___	☐	☐	_____

GENERAL MEDICAL HISTORY

What is your current weight? _____ Height? _____ Usual weight? _____

Recent weight loss or gain in the past 6 months?_____

Place a check by any of the following that have been a problem for you during the last 6 months

Eye problems ☐	Diarrhea ☐	Headaches ☐
Stuffy nose, hay fever ☐	Hemorrhoids ☐	Shaking, tremor ☐
Frequent nose bleeds ☐	Hernia ☐	Anxiety ☐
Fast or irregular heartbeat ☐	Gall bladder problems ☐	Depression ☐
Heart murmur ☐	Hepatitis ☐	Anemia ☐
Dizziness, fainting ☐	Frequent urination at night ☐	Bleeding/bruising from minor injury ☐
Shortness of breath ☐	Sexual problems ☐	Poor circulation ☐
Lung disease ☐	Herpes (oral or genital) ☐	Blood clots ☐
Asthma ☐	Genital or groin injuries ☐	Blood transfusions ☐
Tuberculosis ☐	Pain in joints, arthritis ☐	Fatigue ☐
Heartburn, indigestion ☐	Acne or pimples ☐	Low energy ☐
Gas, cramps, pain ☐	Elevated prolactin ☐	Past history of IV drug use ☐
Blood in stool or black stool ☐	Fever, sweats, chills ☐	Other ☐
Nausea, vomiting ☐	Excessive thirst ☐	☐
Constipation ☐	Temperature intolerance ☐	☐

Please give detail and dates: _____

_____

Please list any major surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			
4			

Please list all medications including: vitamins/herbs/over the counter medication (OTC's):

Medication	Dosage	Frequency	Reason

Do you or have you taken any steroids, performance enhancing agents, or testosterone? _____ Yes _____ No

If yes, please explain: _____

ALLERGIES:

Latex? _____ Yes _____ No If yes, specify reaction: _____

Medications? _____ Yes _____ No Which meds, specify reaction:_____

FAMILY AND GENETIC HEALTH HISTORY—MALE

Are there any known genetic diseases or conditions that run in your family? _____Yes _____No

If yes, which one(s) and whom?_____

Have any of your blood relatives (siblings, children, aunts, uncles, etc.) had birth defects, [e.g., heart, mental retardation, neural tube defect (e.g., spina bifida)], or other? _____Yes _____No

Are you adopted? _____Yes _____No

Ethnic Background: _____

Are you any of the following ethnic groups?			**There is increased risk for:**	**Tested?:**
Caucasian	____ Yes	____ No	Cystic Fibrosis	___Y ____N
English, Irish	____ Yes	____ No	Neural Tube Defects	N/A
Mediterranean (Greek, Italian, Middle Eastern)	____ Yes	____ No	Thalassemia	___Y ____N
Ashkenazi Jewish	____ Yes	____ No	Tay Sachs	____Y ____N
French Canadian	____ Yes	____ No	Tay Sachs	____Y ____N
Cajun	____ Yes	____ No	Tay Sachs	____Y ____N
Asian (Southeast Asian, Chinese, Taiwanese, Filipino, Indian, etc.)	____ Yes	____ No	Thalassemia	____Y ____N
African descent	____ Yes	____ No	Sickle Cell Anemia, Thalassemia	___Y ____N

Please indicate which of the following conditions may be found in your family:

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Neural tube defects (spina bifida, “open spine”, anencephaly)											
Heart defects (“hole in the heart”, etc.)											
Any birth defects requiring surgery (cleft lip, etc.)											
Unusual genitals in boys or girls											
Limb defects (missing or extra fingers, toes, shorten arms or legs)											
Diabetes											
Blindness											
Deafness											
Bone disorders											
Skin Diseases (eczema, melanoma)											
Cancer before age 50 (specify)											
Heart Disease											
Kidney Disease											
High Blood Pressure											
High Cholesterol											
Epilepsy (seizures)											
Clotting disorders (Factor V Leiden, etc.)											
Bleeding disorders (hemophilia, etc.)											
Thalassemia (Cooley’s anemia)											
Mental Illness (schizophrenia, bipolar, etc)											
Mental retardation, autism or learning disabilities											
Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc)											
Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia)											

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Neuromuscular diseases (muscular Dystrophies, etc.)											
Other genetic disorders (Cystic fibrosis, marfan syndrome, neurofibromatosis, sickle cell anemia, PKU, Tay-Sachs disease, Canavan disease, etc.)											
Chromosome Problems (Down syndrome, Klinefelter syndrome)											
Other serious health issue											

Please explain any positive answers:_____

_____

SOCIAL HISTORY—MALE

Current Occupation: _____

Prior Occupation(s): _____

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	☐	☐	☐	
Marijuana	☐	☐	☐	
Alcohol	☐	☐	☐	
Social drugs	☐	☐	☐	
Exercise	☐	☐	☐	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

Were there times during the past month when you experienced little interest in doing things? ☐Yes ☐No

In the past month, have there been times when you felt down, depressed, or hopeless? ☐Yes ☐No

Please comment: _____

_____

REPRODUCTIVE HEALTH HISTORY—MALE PARTNER

This section only needs to be completed if you intend on using partner's sperm for treatment

List all pregnancies you have fathered, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or elective termination (abortion).

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome

Have you ever had a serious exposure to radiation or toxins (e.g. pesticides, toxic chemicals, poisons, herbicides, plastics, organic chemicals, lead, cadmium, industrial by-products, etc.)? _____ Yes _____ No

Have you ever consulted a urologist or male infertility specialist? _____ Yes _____ No

If yes: Year: _____ Reason: _____

Findings / Recommendations: _____

PREVIOUS FERTILITY EVALUATION:
Have you had any of the following tests performed?

Fertility Test:	Yes	No	Date	Result normal? Yes	No	If no, describe:
Semen Analysis	☐	☐	___/___/___	☐	☐	_____
Hormone Blood tests	☐	☐	___/___/___	☐	☐	_____

GENERAL MEDICAL HISTORY—MALE PARTNER

What is your current weight? _____ Height? _____ Usual weight? _____

Recent weight loss or gain in the past 6 months?_____

Place a check by any of the following that have been a problem for you during the last 6 months

Eye problems ☐	Diarrhea ☐	Headaches ☐
Stuffy nose, hay fever ☐	Hemorrhoids ☐	Shaking, tremor ☐
Frequent nose bleeds ☐	Hernia ☐	Anxiety ☐
Fast or irregular heartbeat ☐	Gall bladder problems ☐	Depression ☐
Heart murmur ☐	Hepatitis ☐	Anemia ☐
Dizziness, fainting ☐	Frequent urination at night ☐	Bleeding/bruising from minor injury ☐
Shortness of breath ☐	Sexual problems ☐	Poor circulation ☐
Lung disease ☐	Herpes (oral or genital) ☐	Blood clots ☐
Asthma ☐	Genital or groin injuries ☐	Blood transfusions ☐
Tuberculosis ☐	Pain in joints, arthritis ☐	Fatigue ☐
Heartburn, indigestion ☐	Acne or pimples ☐	Low energy ☐
Gas, cramps, pain ☐	Elevated prolactin ☐	Past history of IV drug use ☐
Blood in stool or black stool ☐	Fever, sweats, chills ☐	Other ☐
Nausea, vomiting ☐	Excessive thirst ☐	☐
Constipation ☐	Temperature intolerance ☐	☐

Please give detail and dates: _____

_____

Please list any major surgeries or hospitalizations in the table below. Include vasectomy, vasectomy reversal, varicocele repair, or any other surgeries:

	Mo. / Year	Procedure	Reason
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4			

Please list all medications including: vitamins/herbs/over the counter medication (OTC's):

Medication	Dosage	Frequency	Reason

Do you or have you taken any steroids, performance enhancing agents, or testosterone? _____ Yes _____ No

If yes, please explain: _____

ALLERGIES:

Latex? _____ Yes _____ No If yes, specify reaction: _____

Medications? _____ Yes _____ No Which meds, specify reaction:_____

FAMILY AND GENETIC HEALTH HISTORY—MALE PARTNER

Are there any known genetic diseases or conditions that run in your family? _____Yes _____No

If yes, which one(s) and whom?_____

Have any of your blood relatives (siblings, children, aunts, uncles, etc.) had birth defects, [e.g., heart, mental retardation, neural tube defect (e.g., spina bifida)], or other? _____Yes _____No

Are you adopted? _____Yes _____No

Ethnic Background: _____

Are you any of the following ethnic groups?			**There is increased risk for:**	**Tested?:**
Caucasian	____ Yes	____ No	Cystic Fibrosis	___Y ____N
English, Irish	____ Yes	____ No	Neural Tube Defects	N/A
Mediterranean (Greek, Italian, Middle Eastern)	____ Yes	____ No	Thalassemia	___Y ____N
Ashkenazi Jewish	____ Yes	____ No	Tay Sachs	____Y ____N
French Canadian	____ Yes	____ No	Tay Sachs	____Y ____N
Cajun	____ Yes	____ No	Tay Sachs	____Y ____N
Asian (Southeast Asian, Chinese, Taiwanese, Filipino, Indian, etc.)	____ Yes	____ No	Thalassemia	____Y ____N
African descent	____ Yes	____ No	Sickle Cell Anemia, Thalassemia	___Y ____N

Please indicate which of the following conditions may be found in your family:

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Neural tube defects (spina bifida, “open spine”, anencephaly)											
Heart defects (“hole in the heart”, etc.)											
Any birth defects requiring surgery (cleft lip, etc.)											
Unusual genitals in boys or girls											
Limb defects (missing or extra fingers, toes, shorten arms or legs)											
Diabetes											
Blindness											
Deafness											
Bone disorders											
Skin Diseases (eczema, melanoma)											
Cancer before age 50 (specify)											
Heart Disease											
Kidney Disease											
High Blood Pressure											
High Cholesterol											
Epilepsy (seizures)											
Clotting disorders (Factor V Leiden, etc.)											
Bleeding disorders (hemophilia, etc.)											
Thalassemia (Cooley’s anemia)											
Mental Illness (schizophrenia, bipolar, etc)											
Mental retardation, autism or learning disabilities											

Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc)											
Endocrine Disorders (adrenal gland, parathyroid, thyroid disorders, Adrenal Hyperplasia)											

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
Neuromuscular diseases (muscular Dystrophies, etc.)											
Other genetic disorders (Cystic fibrosis, marfan syndrome, neurofibromatosis, sickle cell anemia, PKU, Tay-Sachs disease, Canavan disease, etc.)											
Chromosome Problems (Down syndrome, Klinefelter syndrome)											
Other serious health issue											

Please explain any positive answers:_____

_____

SOCIAL HISTORY—MALE PARTNER

Current Occupation: _____

Prior Occupation(s): _____

Have you or do you use any of the following?

	Never	Not in the last 3 months	Yes	List amount, type and frequency (how often-per day / per week)
Tobacco	☐	☐	☐	
Marijuana	☐	☐	☐	
Alcohol	☐	☐	☐	
Social drugs	☐	☐	☐	
Exercise	☐	☐	☐	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? _____

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In the past month, have there been times when you felt down, depressed, or hopeless? ☐Yes ☐No

Please comment: _____