

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 ____ divorced ____ domestic partner Length of Relationship: ____ years

MAILING ADDRESS:

Street: _____ City: _____

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

Home Phone Number: (____) _____ - _____ OK to leave message? Yes No Best # to reach you:

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: _____

How did you hear about SRM?

- Family/Friend
- Internet
- Radio
- Medical office/physician referral
 - 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 a partner (if applicable) 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 a partner (if applicable) 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?

<u>Fertility Test:</u>			<u>Date</u>	<u>Result normal?</u>		<u>If no, describe:</u>
	Yes	No		Yes	No	
Semen Analysis	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Blood tests	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cystic Fibrosis	<input type="checkbox"/> Y <input type="checkbox"/> N
English, Irish	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neural Tube Defects	N/A
Mediterranean (Greek, Italian, Middle Eastern)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thalassemia	<input type="checkbox"/> Y <input type="checkbox"/> N
Ashkenazi Jewish	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tay Sachs	<input type="checkbox"/> Y <input type="checkbox"/> N
French Canadian	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tay Sachs	<input type="checkbox"/> Y <input type="checkbox"/> N
Cajun	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tay Sachs	<input type="checkbox"/> Y <input type="checkbox"/> N
Asian (Southeast Asian, Chinese, Taiwanese, Filipino, Indian, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thalassemia	<input type="checkbox"/> Y <input type="checkbox"/> N
African descent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle Cell Anemia, Thalassemia	<input type="checkbox"/> Y <input type="checkbox"/> N

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

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR Children	OTHER Relatives
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF		
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 Children	OTHER Relatives
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF		
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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: _____
