

MALE PATIENT HISTORY

GYFT CLINIC, LLC

Patient Name: _____ Partner's Name: _____

Date of Birth: _____ Partner's Date of Birth: _____

Duration of Relationship: _____ Duration of Infertility: _____

Nature of Employment: _____

Have you ever been exposed to: Heat Chemicals Toxic Fumes Nuclear Radiation

MEDICAL HISTORY

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

Have you gained or lost greater than 20 lbs in the last year? YES NO

Do you follow a specific diet or have special dietary habits? YES NO please specify _____

What types of vigorous exercise do you regularly engage in?: _____

Do you frequently hot tub, sauna, or steam bath? YES NO

Have you ever had surgery in the pelvic area? YES NO

Have you ever had an injury to the scrotum or groin area? YES NO

If yes, please specify: _____

Have you ever had: (circle all that apply)

- | | | |
|--------------------|-------------------------|--------------------------|
| Scarlet Fever | Kidney Infection | Cystic Fibrosis |
| Rheumatic Fever | Heart Disease | Breast Tenderness |
| Tuberculosis | High Blood Pressure | Breast Soreness |
| Hepatitis | Gallbladder Disease | Breast Discharge |
| Syphilis | Liver Problems | Neurological Problems |
| Gonorrhea | Ulcers | Seizures |
| Mumps | Appendicitis | Epilepsy |
| Colitis | Mumps w/Testes involved | Visual Disturbances |
| Herpes | Diabetes | Dizziness |
| Chronic Bronchitis | Anemia | Loss of Balance |
| Measles, Regular | Arthritis | Chronic Headaches |
| Measles, German | Thyroid Problems | Blood Transfusions |
| Pneumonia | Testes Tumor | Nongonococcal Urethritis |
| Chlamydia | Testes Infection | Parasitic Infection |

Have you ever been treated for infertility before? YES NO If yes, your physician? _____

What cause of infertility was diagnosed? _____

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

- | | |
|--|-------------------------------|
| Clomiphene Citrate (Serophene or Clomid) | Testosterone or male hormones |
| hMG (Pergonal) | hCG (Profasi HP, A.P.L.) |
| Tamoxifen | Fluoxymesterone (Halostestin) |
| Testolactone | GnRh (or LHRH, GRH, Factrel) |
| Bomocriptine (Parlodel) | Other, please specify _____ |

MALE PATIENT HISTORY

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Have you had a varicocele repair? YES NO

Have you had a vasectomy reversal or repair? YES NO

Have you and your partner tried artificial insemination? YES NO

Have you and your partner tried IVF? YES NO

Which of the following tests have you had performed? (circle all that apply)

Semen Analysis

Mycoplasma Test

Sperm Penetration Assay

Testicular Biopsy

Hormonal Testing

Chlamydia Test

Antibody Screening

Chromosome Test

X-Ray or Ultrasound of the Testes

Thyroid Tests

Has your partner had children before with another man? YES NO

Within the last year have you taken prescription medicines? YES NO

List prescriptions and diagnosis for treatment _____

Are you taking over-the-counter medications regularly? YES NO

Have you had a fever over 102 degrees in the past 6 months? YES NO

Do you now or have you ever used: (circle all that apply)

Alcohol: YES NO # per week _____

Cigarettes: YES NO #per day _____

Coffee or other caffeine: YES NO # per day _____

Illicit or Recreational Drugs _____

(If you would feel more comfortable please discuss this directly with your physician rather than writing it down.)

Is there a family history of infertility? YES NO Are you circumcised? YES NO

When you were a child, were both testes descended? YES NO

At what age did you begin growing a beard regularly? _____

Have you ever produced a child with another partner? YES NO

Do you have trouble getting erections? YES NO Maintaining an erection? YES NO

Do you have trouble with ejaculation? Premature? Retrograde? YES NO

Do you feel that some of your ejaculate is deposited in the vagina? YES NO

Do you ever have orgasms without ejaculation while masturbating? YES NO

Do you have any 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 ovulation? _____

Have you noticed a change in your sex drive recently? _____