



DELAWARE VALLEY INSTITUTE
OF FERTILITY & GENETICS
6000 Sagemore Drive
Suite 6102
Marlton, NJ 08053
Tel#: 856-988-0072 Fax#: 856-988-0056

MALE PATIENT HISTORY IDENTIFYING INFORMATION

Date _____

Name _____ Partner's name _____

Address _____

Telephone no. Home _____ Work _____

Date of birth _____ Partner's date of birth _____

Insurance company _____ I.D.# _____

Name of employer _____

Employer address _____

Job title/description _____

E-mail address _____

MEDICAL HISTORY

Height: _____ Blood pressure: _____

Body weight: Current _____ Last year _____ Teenage years _____

BMI [body weight (lbs.) x 705 / height (")²] = _____

Blood type: ABO _____ Rhesus ()ve _____ Du()ve _____ Antibodies()ve _____

Have you ever received transfusions? _____ When? _____

Have you received immunizations to rubella? _____ When? _____

Do you consume any special foods (health or diet products)? _____

Do you undertake any exercise on a regular basis? _____

How often? _____/week. Type: _____

Do you take any vitamins/minerals/herbs? _____

Do you take over-the-counter medication(s) on a regular basis? _____

Do you consume alcohol? _____/week. Do you use tobacco? _____/day.

Do you use recreational drugs? _____/week.

Are you currently receiving therapy or have you received any therapy in the recent past? _____

Were you ever exposed to radiation, toxic agents, or chemicals? _____

Are you exposed to high temperatures in your work environment? _____

Does your job involve driving long distances? _____ Please explain. _____

Are you under stress at work? _____ At home? _____

Allergies _____

Have you ever had any of the following conditions? (check all that apply):

- | | | | |
|----------------------------|--------------------------|-----------------|--------------------------|
| Anemia | <input type="checkbox"/> | Heart condition | <input type="checkbox"/> |
| Abnormal bleeding/bruising | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> |
| Sickle Cell or thalassemia | <input type="checkbox"/> | Arrhythmias | <input type="checkbox"/> |
| Autoimmune disease | <input type="checkbox"/> | Palpitations | <input type="checkbox"/> |

- | | | | |
|-----------------------------|--------------------------|------------------------|--------------------------|
| Chest pain | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Muscle pain | <input type="checkbox"/> |
| Joint pain | <input type="checkbox"/> | Colitis | <input type="checkbox"/> |
| Chronic headaches | <input type="checkbox"/> | Chronic constipation | <input type="checkbox"/> |
| Color blindness | <input type="checkbox"/> | Cirrhosis/jaundice | <input type="checkbox"/> |
| Head trauma | <input type="checkbox"/> | Pancreatitis | <input type="checkbox"/> |
| Visual disturbances | <input type="checkbox"/> | Hiatus hernia | <input type="checkbox"/> |
| Poor sense of smell | <input type="checkbox"/> | Enteritis/appendicitis | <input type="checkbox"/> |
| Dizziness/loss of balance | <input type="checkbox"/> | Chronic diarrhea | <input type="checkbox"/> |
| Epilepsy/seizures | <input type="checkbox"/> | Peptic ulcer disease | <input type="checkbox"/> |
| Neurological problems | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> |
| Insomnia | <input type="checkbox"/> | Gallbladder problems | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | Liver problems | <input type="checkbox"/> |
| Tremors | <input type="checkbox"/> | Repetitive cystitis | <input type="checkbox"/> |
| Increased thirst | <input type="checkbox"/> | Kidney infections | <input type="checkbox"/> |
| Changes in appetite | <input type="checkbox"/> | Kidney stones | <input type="checkbox"/> |
| Increased sweating | <input type="checkbox"/> | Frequent urination | <input type="checkbox"/> |
| Chronically warm or cold | <input type="checkbox"/> | Painful urination | <input type="checkbox"/> |
| Painful swallowing | <input type="checkbox"/> | Urgency | <input type="checkbox"/> |
| Change of voice/hoarseness | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> |
| Craving for salt | <input type="checkbox"/> | Scarlet fever | <input type="checkbox"/> |
| Loss of scalp hair | <input type="checkbox"/> | Parasitic infections | <input type="checkbox"/> |
| Growth of hair on face/body | <input type="checkbox"/> | Cancer | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Asthma | <input type="checkbox"/> |
| Thyroid problems | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | Measles: German | <input type="checkbox"/> |
| Mumps | <input type="checkbox"/> | Measles: Regular | <input type="checkbox"/> |
| Pneumonia | <input type="checkbox"/> | Chronic bronchitis | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | | |

SURGICAL HISTORY

YES NO

- | | | |
|---|--------------------------|--------------------------|
| Teeth extraction | <input type="checkbox"/> | <input type="checkbox"/> |
| Tonsillectomy/adenoidectomy | <input type="checkbox"/> | <input type="checkbox"/> |
| Appendectomy | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any fractures? | <input type="checkbox"/> | <input type="checkbox"/> |
| Hernia | <input type="checkbox"/> | <input type="checkbox"/> |
| Undescended testes | <input type="checkbox"/> | <input type="checkbox"/> |
| Varicocele repair | <input type="checkbox"/> | <input type="checkbox"/> |
| Circumcision | <input type="checkbox"/> | <input type="checkbox"/> |
| Testicular torsion | <input type="checkbox"/> | <input type="checkbox"/> |
| Injury to testes | <input type="checkbox"/> | <input type="checkbox"/> |
| Urethral or other genitourinary surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Surgery (please explain) _____ | | |

SEXUAL HISTORY

YES NO

Have you had any sexually transmitted diseases?
(Syphilis, gonorrhea, herpes, Chlamydia, warts, HIV, prostatitis)

Please explain: _____

Urethral infection

Lesions at genital organs

Do you have trouble getting an erection?

Do you have trouble maintaining an erection?

Have you ever tried to produce a child with another partner?

Do you have orgasms without ejaculation?

Do you have retrograde ejaculations?

How many times per week do you and your partner have intercourse?

_____/week _____/other

FAMILY HISTORY

Is there a family history of any of the following disorders? (check all that apply)

Hypertension

Sickle cell or thalassemia

Heart condition

Cystic fibrosis

Strokes

Hemophilia (bleeding disorder)

Infertility

Hydrocephalus (fluid in skull)

Cancer

Thyroid condition

Diabetes

Birth defect

If you have answered yes to any of the above, please explain in detail:

Did your mother take DES?

Mother's age _____

Father's age _____

Siblings: Male _____

Female _____

HISTORY OF FERTILITY THERAPY

Did you undergo evaluation or infertility treatment in the past?

If yes, name of physician _____

What was the diagnosis of the infertility? _____

Which of the following tests did you have performed? (check all that apply).

Blood tests for hormonal evaluation

Chromosomal analysis

Scrotal ultrasound

Semen cultures

Chlamydia testing

Testicular biopsy

CBC

Chem 20

Semen analysis

What type of medical treatment did you receive? _____

What type of surgical treatment did you receive? _____
