Advanced Reproductive Center
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Reproductive Health and Fertility Center

MALE HISTORY

NAME:_____ **Date:**_____

Pregnancy History

Have you fathered any pregnancies with previous partners? _____

If yes, list the pregnancies below:

Date	Outcome (e.g. live birth, ectopic, miscarriage,	Male or female	Any health issues with the child?

Have you had any infertility problems with previous partners? _____

Previous infertility testing and/or treatment

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If you have had previous infertility testing and/or treatment please have those records forward to our office before your appointment.

Have you ever had a semen analysis?_____
If so, list the results below:

Date of semen analysis	Volume	Concentration	Motility	Morphology

Describe any additional details regarding previous infertility testing and/or treatment.

_____

_____

_____

Surgical history

Previous surgeries:

Surgery	Date	Surgical findings	Complications, if any

Name:_____

Any additional details regarding previous surgeries:

Medical History

List any medical problems such as high blood pressure, cancer, diabetes, asthma, arthritis, migraine headaches, thyroid problems, heart disease etc.

Erectile or ejaculatory dysfunction?_____

Family History

Family members' medical history including high blood pressure, cancer, diabetes, asthma, arthritis, mental retardation, heart disease etc.

Medical problem	Family member(s) affected (e.g. mom, maternal grandmother, sister etc.)

Do you have any history of infertility or multiple miscarriages in your family?

Any additional details regarding medical problems that run in your family:

Medications

Medications including vitamins and herbal medications:

Medication	Dose and frequency (e.g. 20 mg 3 times a day)	Reason for taking the medication

Allergies:

Any additional details regarding medications or allergies:

Name: _____

Social History

Do you smoke?_____
If so, how many years have you smoked? _____ and
How many cigarettes do you smoke a day? _____

Do you drink alcohol? _____
If so, how many alcoholic beverages do you drink per day?_____

Do you use any recreational drugs?_____
If so, what drugs do you use?_____ and
How often do you use them?_____

Additional Information

Any additional information you want to share?

_____

_____

_____

Signature:_____ **Date:**_____