Urology Clinic of Utah Valley

MEDICAL HISTORY FORM FOR INFERTILITY

In order to assess your Infertility and to give you the best medical treatment possible, we would appreciate you completing the following questionnaire. There is also a section for your partner to complete as well. All information will be held in strict confidence. Please complete the entire questionnaire. Thank you.

PATIENT (Male)

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Birth Date: _____ Age: _____

Years Married: _____ Years Trying to Conceive: _____

Referring Physician: _____ Phone: _____

Birth Control Method: _____

Previous pregnancy with spouse/partner:

Live Births (0-9) _____Miscarriages (0-9) _____ Abortions (0-9) _____

Previous pregnancy with someone other than your spouse or partner:

Live Births (0-9) _____Miscarriages (0-9) _____ Abortions (0-9) _____

MEDICAL HISTORY:

1. Did you have undescended testicles at birth? Yes _____ No _____

   If yes, (circle) Right Left Bilateral

2. Have you ever had a hernia operation? Yes _____ No _____

   If yes, (circle) Right Left Bilateral

3. At what age did you start to shave? _____

4. Approximately at what age did you start going through puberty? _____

5. How often do you shave now? _____

6. Have you ever had the mumps? Yes _____ No _____

   If yes, did it affect your testicles? Yes _____ No _____

7. Have you ever had any of the following?

   A. Diabetes (sugar) Yes _____ No _____

   B. Cancer Yes _____ No _____

   C. Neurological Disorders (e.g. multiple sclerosis, etc.) Yes _____ No _____

   D. Cystic Fibrosis Yes _____ No _____

   E. Bladder or pelvic surgery Yes _____ No _____

   F. Other medical problems (please specify)

   _____

8. Have you ever had urinary tract infections? Yes _____ No _____

9. Have you ever had a prostate infection? Yes _____ No _____

10. Have you ever had infection of the Testicles or epididymis? Yes _____ No _____

11. Have you ever had blood in your ejaculate (semen)? Yes _____ No _____

12. Have you ever had a venereal disease? Yes _____ No _____

13. Have you ever had a white, green, or yellow discharge from the end or your penis? Yes _____ No _____

14. Have you ever had surgery for:

   A. Vasectomy Yes _____ No _____

   B. Varicocelectomy (tying off dilated veins to the scrotum) Yes _____ No _____

   C. Testicular or scrotal surgery Yes _____ No _____

   D. Penis surgery Yes _____ No _____

15. Have you ever had trauma (injury) to your testicles? Yes _____ No _____

   If yes, Please specify: _____

MEDICATIONS, DRUGS, GONADOTOXINS, OCCUPATIONAL HAZARDS:

1. Do you smoke: Yes _____ No _____

   If yes, how long (years) _____, how many packs daily _____.

2. Do you now or have you ever used any of the following drugs?

	No	Yes	Amount	Frequency
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Others	_____	_____	_____	_____

3. Please list any prescription medications you currently or frequently take:

   _____

   _____

4. Please list any over-the-counter medications you currently or frequently take:

   _____

   _____

5. Have you ever taken any steroids? Yes _____ No _____

6. Have you ever had any chemotherapy? Yes _____ No _____

   If yes, please specify: _____

7. Have you ever had radiation therapy
   or been exposed to radiation? Yes _____ No _____

8. Do you frequently take hot baths, saunas, or steam baths
   or exposed to temperature extremes (hot or cold) Yes _____ No _____

9. Have you ever been exposed to chemicals, solvents and their fumes,
   or any toxins/poisons (e.g. Pesticides)? Yes _____ No _____

10. Is your occupation very stressful? Yes _____ No _____

SEXUAL HISTORY:

1. How frequently do you have intercourse? Yes _____ No _____
2. How often do you masturbate? Yes _____ No _____
3. Do you have any problems getting or maintaining an erection? Yes _____ No _____

   If yes, please specify _____
4. Do you use any form of lubrication for intercourse? Yes _____ No _____
5. Is intercourse ever painful for you or your partner? Yes _____ No _____

   If yes, please specify _____
6. Have you noticed any change in your sexual desire or drive? Yes _____ No _____

FAMILY HISTORY:

Are there any problems with Infertility or physical Development that runs in your family? Yes _____ No _____

If yes, please specify _____

REVIEW OF SYSTEMS:

1. Do you frequently get colds, upper respiratory tract infections, or sinus infections? Yes _____ No _____
2. Have you had a fever of viral illness recently? Yes _____ No _____
   If yes, please specify _____
3. Do you have significant problems with your sense of smell? Yes _____ No _____
4. Have you noticed any problems with your peripheral vision? Yes _____ No _____
5. Have you noticed any secretions or tenderness in your breasts? Yes _____ No _____
6. Are you overly sensitive to heat or cold? Yes _____ No _____
7. Do you have any testicular pain of discomfort? Yes _____ No _____

PARTNER (Female)

Name: _____

Date of Birth: _____ Age: _____

Previous pregnancies with any other partners: (not including spouse) _____

Live births (0-9) _____ Miscarriages (0-9) _____ Abortions (0-9) _____

List any history of medical gynecological problems
(e.g. pelvic or vaginal infections, endometriosis, etc.)

_____

_____

_____

Do you have regular menstrual cycles/periods? Yes _____ No _____

Have you been evaluated for infertility? Yes _____ No _____

Physician's name and address:

_____

_____

Tests performed:

	Normal	Abnormal	Not Done
Ultrasound	_____	_____	_____
Hysterosalpingogram	_____	_____	_____
Laparoscopy	_____	_____	_____
Hormone Levels	_____	_____	_____
Postcoital Test	_____	_____	_____

Others _____

Please list any treatment for infertility a dates
(i.e. Clomid, Pergonal, Intrauterine insemination, etc.)

_____

_____