Welcome

To better focus your visit with the doctor based on your needs, please complete this form prior to your initial visit. Thank you.

Personal Information

Name: ______________________________________ Today's Date: __________

Social Security Number: _______-_____-_______ Date of Birth: ___/___/_____

Address: ____

____

____

Phone numbers Cell _________--___________--___________

Home _________--___________--___________

Work _________--___________--___________

Email address: ____

Partner's Name (if applicable): __________________ Date of Birth: ___/___/_____

Partner's Social Security Number: _________-_______-_________

Who referred you to us?____

Your Urologist (if you have one): ____

Your Internist/ Family Physician (if you have one): _____________________________

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Fertility History

What is the reason for your visit today and how long have you been trying to conceive?

____

____

Have you ever achieved a pregnancy in the past? ☐ Yes ☐ No

If yes, is it with your current partner? ☐ Yes ☐ No

If yes, when? ____

Have you ever had a complete semen analysis performed? ☐ Yes ☐ No

If yes, when, where and results: ____

____

____

____

Have you ever seen a doctor to evaluate your fertility? ☐ Yes ☐ No

If yes, physician's name and when: ____

____

____

What is your diagnosis and how has have you been treated?

____

____

____

____

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

Do you use lubricants? ☐ Yes ☐ No

If yes, which one(s): ____

Medical History

Do you have any medical problems? ☐ Yes ☐ No If yes, which one(s)? Check all that apply:

☐ Alcoholism
☐ Anxiety disorder
☐ Arthritis
☐ Bipolar disorder
☐ Bleeding disorder
☐ Blood clot in leg or lung
☐ Cancer? Type:_______________
☐ Colitis
☐ Epilepsy
☐ Erectile dysfunction
☐ Gallbladder problems
☐ Heart Disease
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ HIV
☐ Neurological Problems
☐ Nongonococcal Urethritis
☐ Other:_________________
☐ Poor Sense of Smell
☐ Spinal cord problems
☐ Seizures
☐ Substance (drug) abuse
☐ Thyroid disease

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☐ Color Blindness
☐ Liver Problems
☐ Tuberculosis
☐ Diabetes
☐ Loss of balance
☐ Ulcers
☐ Depression

Urological History

Do you ever have difficulties achieving an erection? ☐ Yes ☐ No

If yes, how often? ____

Do you ever have difficulties ejaculating? ☐ Yes ☐ No

If yes, how often? ____

Have you ever had a serious injury to your genitals? ☐ Yes ☐ No

If yes, when? ____

Have you ever had any infection involving:

☐ Epididymis
☐ Prostate
☐ Testicles
☐ Gonorrhea
☐ Sexually transmitted diseases
☐ Urethritis
☐ Herpes
☐ Syphilis
☐ Urinary tract (bladder) infection

Have you ever had:

Blood in semen? ☐ Yes ☐ No

Pain after ejaculating? ☐ Yes ☐ No

Pain or swelling of testicles? ☐ Yes ☐ No

Fever in the last 3 months? ☐ Yes ☐ No

Surgical History

Have you ever had surgery:

On the urinary tract, bladder or prostate? ☐ Yes ☐ No

Vasectomy? ☐ Yes ☐ No If yes, when? ______________________________

Vasectomy reversal? ☐ Yes ☐ No If yes, when? ______________________________

Other microsurgery for infertility? ☐ Yes ☐ No If yes, when? ____________________

Hernioorapy? ☐ Yes ☐ No

Varicocelectomy? ☐ Yes ☐ No If yes, when? ______________________________

Testis biopsy? ☐ Yes ☐ No

Penile surgery? ☐ Yes ☐ No

Removal of a testicle? ☐ Yes ☐ No

Other surgeries? If yes, what it is? ____

____

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Medications

Do you take any prescription or over-the-counter medications regularly? ☐ Yes ☐ No

If yes, please list: ____

____

____

Have you ever taken any of the following medications? ☐ Yes ☐ No If yes, which one(s)?

Check all that apply:

☐ Allopurinol	☐ Dilantin	☐ Testosterone
☐ Antidepressants	☐ hCG injections	☐ Tagamet (cimitidine)
☐ Antihypertensive medications	☐ Immunosuppressant drugs	☐ Tranquilizers
☐ Chemotherapy for cancer	☐ Insulin	☐ Zantac (ranitidine)
☐ Cholesterol-lowering medications	☐ Interferon	☐ Zovirax (acyclovir)
☐ Clomid	☐ Steroids	☐
☐ Colchicine	☐ Sulfasalazine	☐

Do you have any allergies? ☐ Yes ☐ No

If yes, please list: ____

____

What is your current weight? (in lbs.) ____________ What is your height? (in inches) ____________

Have you lost or gained more than 10 pounds of weight in the last year? ☐ Yes ☐ No

Do you follow a particular food diet or have any special dietary habits? ☐ Yes ☐ No

If yes, what is it? ____

Do you exercise regularly? ☐ Yes ☐ No

If yes, type of exercise do you do and for how many hours per week? ____________________

____

____

Have you ever had an eating disorder? (anorexia, bulimia) ☐ Yes ☐ No

If yes, what is it? ____

____

Social History

What is your ethnicity? ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic

☐ Indian ☐ Native American ☐ Other: ________________________________

What do you do professionally? ____

Have you ever been exposed to toxins, poisons, pesticides, radiation or solvents? ☐ Yes ☐ No

If yes, what? ____

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You are: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you currently use or have you recently used (check all that apply):

☐ Caffeine. How many cups of coffee/ caffeinated tea/ cola do you have in one week?_____________

☐ Alcohol. How many glasses of alcohol do you usually drink per week? ______________________

☐ Tobacco. How many cigarettes per day? ____

☐ Recreational Drugs. (Marijuana, Cocaine, etc.) Which one(s) and how often? _________________

____

____

Family History

Does anyone in your family have infertility? ☐ Yes ☐ No

If yes, who: ____

Does anyone in your family have recurrent abortions (2 or more miscarriages)? ☐ Yes ☐ No

If yes, who: ____

Are there any children in the family with birth defects or mental retardation? ☐ Yes ☐ No

If yes, who: ____

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