



**Bedford
Commons**
OB-GYN, P.A.

Fertility Care Program Medical History and Information

Male

Please Complete the Following:

Date: _____

Name: _____ Date of Birth: _____ Age: _____

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

Primary Care Provider: _____ Phone: _____

Usual Weight: _____ Height: _____

Current Medications: _____

Allergies to medications, eggs, latex: _____

Medical History (circle all that apply)

History of mumps? Complications?

History of undescended testicles?

Any illness and/or fever in last 3 months?

Have you ever had any injury, cancer, or tumor of the testicles?

Have you ever had x-rays of your groin area?

Have you ever been treated for a genital infection? (i.e., chlamydia, gonorrhea, syphilis, herpes, prostrate)

Have you ever had chemotherapy for cancer?

Other medical problems – past and present. List treatments and dates.

Surgical History (circle all that apply; give date of surgery)

1. Hernia
2. Testicular surgery
3. Pelvic surgery
4. Varicocele repair
5. Vasectomy/reversal
6. Did you undergo any bladder or penis surgery as a child?

Sexual History

Do you have any difficulty having or maintaining an erection? ___ yes ___ no

Do you have premature ejaculations? ___ yes ___ no

Have you ever had children with another partner? ___ yes ___ no

Do you have any other sexual difficulties? Explain: _____

Male Medical History and Information

Social History

Occupation: _____
How many caffeinated beverages (coffee, tea, soda) do you drink/day? _____
Have you ever or do you smoke cigarettes? ___ yes ___ no
How many/day? _____ When did you quit? _____
Do you drink alcohol? ___ yes ___ no
_____ drinks/week Type: _____
Do you use recreational drugs? ___ yes ___ no
Type: _____

Emotional Status

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures. _____

Additional Information/Complications:

Patient Signature: _____ Date: _____
Clinician Signature: _____ Date: _____