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MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____
Name _____ Partner's Name _____
Address _____
Telephone Number - Day: () _____ Evening: () _____
Date of Birth _____ Partner's Date of Birth _____ Duration of Relationship _____ Duration of Infertility _____
Insurance Company _____ Insurance I.D. # _____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment — title(s), location, brief description, number of years employed:

Are you or have you ever been exposed to any of the following during employment or military service:

Heat Toxic Fumes Other Specify: _____
 Chemicals Nuclear Radiation _____

III. MEDICAL HISTORY

YES NO

Weight _____ Height _____ Blood Type (if known) _____

Have you lost greater than 20 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, specify: _____

List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:

Exercise: _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age _____

Do you frequently take saunas or steam baths? YES NO

Have you ever had surgery in the pelvic area? YES NO

If yes, specify date and type of surgery: _____

Have you ever received X-rays in the pelvic area for therapy or diagnosis? YES NO

If yes, explain: _____

Do you have or have you ever had (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Parasitic Infection |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Breast Milky Discharge | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cancer? Specify _____ | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Testes Infection |
| | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Testes Injury |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Testes Tumor |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Measles: German | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mumps with Testes Involved | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Any Allergies? List _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nongonococcal Urethritis | _____ |

	YES	NO
Have you ever been treated for cancer?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain therapy: _____		
Within the last year, have you taken any prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list all prescriptions and problems for which you were taking them: _____		

Are you taking any over-the-counter medications on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list all medications and diagnoses: _____		

Have you had a high fever (over 102°F) during the past 3-4 months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use or have you ever used (check all that apply);		
<input type="checkbox"/> Alcohol - How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____		
<input type="checkbox"/> Cigarettes - Number of packs per day _____		
<input type="checkbox"/> Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____		

IV. SEXUAL HISTORY

	YES	NO
Are you circumcised?	<input type="checkbox"/>	<input type="checkbox"/>
When you were a child, were both testes descended into the scrotum?	<input type="checkbox"/>	<input type="checkbox"/>
At what age did you begin shaving regularly or start to grow a beard? _____		
How many times have you been married? _____		
Have you ever produced a child with another partner?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how long did it take to produce a child? _____ When was this (dates)? _____		
Have you ever <i>tried</i> to produce a child with another partner?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble getting an erection?	<input type="checkbox"/>	<input type="checkbox"/>
Maintaining an erection?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble with ejaculations?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, <input type="checkbox"/> Premature ejaculations <input type="checkbox"/> Retrograde ejaculations?		
Do you feel that some of your ejaculate is deposited in the vagina?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have orgasms without ejaculation during masturbation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any discharge from the penis?	<input type="checkbox"/>	<input type="checkbox"/>
How many times per week do you and your partner now have intercourse? _____		
How many times do you have intercourse around ovulation? _____		
Have you noticed a change in your sexual drive recently?	<input type="checkbox"/>	<input type="checkbox"/>

V. FAMILY HISTORY

	YES	NO
Is there a family history of infertility?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who (list all members and relationship to you): _____		

Is there a history of hormonal disorders in your family?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list who (relationship to you) and what type: _____		

VI. HISTORY OF FERTILITY THERAPY

YES NO

Have you been treated for infertility before?

If yes, who was your physician? _____

What cause of infertility was diagnosed? _____

What drugs have you taken for infertility? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> clomiphene citrate (Serophene®, Clomid®) | <input type="checkbox"/> hCG (Profasi®, A.P.L.®) |
| <input type="checkbox"/> hMG (Pergonal®) | <input type="checkbox"/> fluoxymesterone (Halotestin®) |
| <input type="checkbox"/> tamoxifen | <input type="checkbox"/> GnRH or LHRH (Factrel®) |
| <input type="checkbox"/> testolactone | <input type="checkbox"/> urofollitropin or FSH (Metrodin®) |
| <input type="checkbox"/> bromocriptine (Parlodel®) | <input type="checkbox"/> Other - Specify _____ |
| <input type="checkbox"/> testosterone or Male Hormone | <input type="checkbox"/> None |

Have you ever had varicocele repair?

If yes, when? _____

Have you ever had vasectomy reversal or repair?

If yes, when? _____

Have you and your partner ever tried artificial insemination?

If yes: using your sperm? donor sperm?

Have you and your partner ever tried in vitro fertilization?

If yes, when and explain: _____

Which of the following tests have you had performed? Check all that apply and the results if known:

- | | |
|--|----------------------------|
| <input type="checkbox"/> Semen Analysis | When? _____ Results: _____ |
| <input type="checkbox"/> Chlamydia Test | When? _____ Results: _____ |
| <input type="checkbox"/> Mycoplasma Test | When? _____ Results: _____ |
| <input type="checkbox"/> Antibody Test | When? _____ Results: _____ |
| <input type="checkbox"/> Hamster Egg Test | When? _____ Results: _____ |
| <input type="checkbox"/> Chromosome Test | When? _____ Results: _____ |
| <input type="checkbox"/> Testicular Biopsy | When? _____ Results: _____ |
| <input type="checkbox"/> X-ray or Ultrasound of Testes | When? _____ Results: _____ |
| <input type="checkbox"/> Hormonal Tests (FSH, LH, prolactin, testosterone) | When? _____ Results: _____ |
| <input type="checkbox"/> Thyroid Tests | When? _____ Results: _____ |
| <input type="checkbox"/> Other - Specify _____ | When? _____ Results: _____ |

Is your partner currently seeing a doctor for evaluation of infertility?

If yes, specify physician name and location: _____

Does the doctor feel that your partner has an infertility problem?

If yes, what is the diagnosis and how is she being treated? _____

Has she ever had children with another man?

If yes, when? _____