

Part 1: Patient Contact and Insurance Information

| Female / Patient | | |
|--|---------------|----------------|
| Social Security No. | Date of Birth | Patient ID No. |
| Name (Last, First, Middle Initial) | | Nickname |
| Address | | |
| City/State/Zip | | |
| Home Phone | Work Phone | Cell phone |
| Which number would you prefer that we leave messages: Circle all that apply: Home / Work / Cell Phone | | |
| Sex | Race | Age |
| Marital Status (Circle one): Married / Divorced / Single / Other Duration of current relationship: Years | | |
| Have you been married previously? No / Yes: How many times? | | |
| Emergency Contact | | Day Phone |

| Spouse / Partner | | |
|--|---------------|----------------|
| Social Security No. | Date of Birth | Patient ID No. |
| Name (Last, First, Middle Initial) | | Nickname |
| Address | | |
| City/State/Zip | | |
| Home Phone | Work Phone | Cell phone |
| Which number would you prefer that we leave messages: Circle all that apply: Home / Work / Cell Phone | | |
| Sex | Race | Age |
| Marital Status (Circle one): Married / Divorced / Single / Other Duration of current relationship: Years | | |
| Have you been married previously? No / Yes: How many times? | | |
| Night Phone | Relationship | |

| Patient's Employment | |
|----------------------|------------|
| Company Name | Occupation |
| Address | |
| City / State / Zip | |

| Spouse / Partner Employment | |
|-----------------------------|------------|
| Company Name | Occupation |
| Address | |
| City / State / Zip | |

| Primary or Patient's Insurance | |
|--------------------------------|--------------|
| Insurance Company name | |
| P.O. Box / Address | |
| City / State / Zip | |
| Policy ID Number | Group Number |
| Policy Holder's Name | Day Phone |

| Secondary or Spouse/Partner Insurance | |
|---------------------------------------|--------------|
| Insurance Company name | |
| P.O. Box / Address | |
| City / State / Zip | |
| Policy ID Number | Group Number |
| Policy Holder's Name | Day Phone |

| Who Referred You to RSC? | | |
|--------------------------|---------------------|---------|
| Physician | Phone | |
| Address | | |
| Former Patient | Family | Friend |
| Insurance Company | Radio Advertisement | Website |

| OB/GYN and Primary Care Physician Information | |
|---|-------|
| OB/GYN Name | Phone |
| Address | |
| Primary Care Physician | Phone |
| Address | |

| |
|--|
| Clinician Notes (for office use only) |
|--|

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS A CLAIM TO THE ABOVE NAMED INSURANCE CARRIER.
 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY PHYSICIAN

Signature of Patient: _____

Date: _____

Part 2: Female Medical History and Information

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

General Information

- Reason for visit: Infertility testing/evaluation Insemination IVF
Other _____
- What are your expectations for this visit? _____
- What questions do you want answered at this visit? _____

Do you have any **personal, ethical, or religious objections** to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? No Yes

If yes, please explain: _____

Gynecologic History

Menstrual History

- Number of days between the start of one period to the start of the next period: _____ days
- How many days of bleeding do you have? _____ days
- Dates of the 1st day of your last 2 menstrual periods: ____/____/____; ____/____/____
- Menstrual cycle pattern (check all that apply): Regular periods Irregular periods Spotting before periods No periods
 Heavy periods Light periods Bleeding between periods
- If you do not have periods, at what age did you stop having them? _____ years old
- Age when you had your first period: _____ years old
- Age when you first noticed: Breast development: _____ years old; Pubic hair: _____ years old;
Underarm hair: _____ years old
- How many periods do you have per year? _____
- Do you need any medication to bring on a period? No Yes – what type? _____
- Do you have **severe** cramping or pelvic pain with your periods?
 No Yes: ___ Always ___ Sometimes ___ Recently ___ in the past
- Did your mother take DES when she was pregnant with you? No Yes Don't know

Contraceptive History

- Which of the following forms of birth control have you used? (check all that apply) None
- Condoms – dates of use _____ Diaphragm – dates of use _____ IUD – dates of use _____
 - Foam or jelly – dates of use _____ Withdrawal – dates of use _____ Rhythm – dates of use _____
 - Birth control pills – dates of use _____ Complications? _____
 - Injectable contraception – dates of use _____ Complications? _____
(Depo-Provera, Lunelle, etc)
 - Skin patch – dates of use _____ Complications? _____
 - Tubal sterilization procedure (tubes tied) – date (month/year) ____/____ Tubes untied – date (month/year) ____/____

Clinician Notes (for office use only)

Part 2: Female Medical History and Information

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

Sexual History

- How many times do you have intercourse per week? _____ times None Not applicable
- Have you ever used over-the-counter ovulation kits to time intercourse? No Yes
If yes, does it show ovulation? No Yes – what cycle day? _____ Unsure
- Do you have pain with intercourse? No Yes
- Do you use lubricants (K-Y Jelly, etc.) during intercourse? No Yes – what types? _____
- Have you ever had any of the following sexually transmitted diseases or pelvic infections? (check all that apply) None
 Chlamydia – date _____ Gonorrhea – date _____ Herpes – date _____ Genital warts/HPV – date _____
 Syphilis – date _____ HIV/AIDS – date _____ Hepatitis – date _____ Other – date _____
- When was your last pap smear (month/year)? ____/____ Normal Abnormal
- Have you ever had an abnormal pap smear? No Yes – date _____
 Have you undergone any procedures as a result of an abnormal pap smear? No Yes (check all that apply)
 Colposcopy Cryosurgery (freezing) Laser treatment Conization LEEP procedure

Obstetrical History

- Have you ever been pregnant? No Yes – if yes, please complete below:
- Total number ALL pregnancies _____ Number Miscarriages (less than 20 weeks) _____
- Number ectopic/tubal pregnancies _____ Number elective terminations (abortions) _____
- Number full term deliveries _____ of these, how many were live births? _____ How many were stillborn? _____
- Number premature (less than 37 weeks) deliveries? _____ of these, how many were live births? _____ How many were stillborn? _____
- Any pregnancies with birth defects? No Yes – explain _____

| Date pregnancy ended or delivered | How Long to Conceive | Treatments to conceive | Delivery type /D&C/Complications | Current Partner? |
|-----------------------------------|----------------------|------------------------|----------------------------------|--|
| 1. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Clinician Notes (for office use only)

Part 2: Female Medical History and Information

Name: _____
(Please Print)
Date of Birth: _____
(MM/DD/YYYY)

Medical-Surgical History

Medical History

Height _____

Weight _____

- Are you allergic to any medications? No Yes (Please list and describe reactions)

- Are you allergic to any foods (peanuts, sesame, olive oil, shellfish, etc.)? No Yes (Please list and describe reactions)

- Are you allergic to latex? No Yes (Please list and describe reactions)

- List any medications you are currently taking, including over the counter medications: _____

- Do you take any herbal medicines/vitamins or health food store supplements? No Yes (Please list) _____

- Have you had Chickenpox? No Yes – age _____ Don't Know
- Do you know your blood type? No Yes _____
- Do you have any medical problems? No Yes (Please list types, dates, and treatments)
 - (1) _____
 - (2) _____
 - (3) _____
 - (4) _____
 - (5) _____

Surgical History

- Have you had any surgeries? No Yes (List all surgeries in chronological order.)

| <u>Year</u> | <u>Reason and Type of surgery</u> |
|-------------|-----------------------------------|
| _____ | (1) _____ |
| _____ | (2) _____ |
| _____ | (3) _____ |
| _____ | (4) _____ |
| _____ | (5) _____ |
| _____ | (6) _____ |
| _____ | (7) _____ |
- Did you have any anesthesia problems? No Yes (describe) _____

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ None
- Have you smoked cigarettes? Never Yes How many/day? _____ How many years? _____
- Do you still smoke? No – when did you quit (year)? _____ Yes
- Do you drink alcohol? No Yes
 - Beer - # per week _____ Wine - # per week _____ Liquor - # per week _____
- Do you use marijuana, cocaine, or any other recreational drugs? No Yes – describe _____
- Do you exercise? No Yes – describe _____
- Are you aware of any radiation exposures other than X-rays? No Yes – describe _____

Part 2: Female Medical History and Information

Review of Systems

General

- Recent weight gain or loss
- Anorexia/bulimia
- Lack of energy
- Fever/chills
- Other _____
- None

Endocrine/Hormonal

- Diabetes
- Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperature intolerance – hot flashes or feeling cold
- Other _____
- None

Gastrointestinal

- Nausea/Vomiting
- Diarrhea
- Ulcers
- Hepatitis
- Blood in your stools
- Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn's)
- Other _____
- None

Musculoskeletal

- Increased muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myesthenia Gravis
- Other _____
- None

Mental Health Problems

- Depression
- Anxiety disorder
- Schizophrenia
- Bipolar disorder
- Other _____
- None

Head, Eyes, Ears, Nose, Throat

- Dizziness
- Loss of sense of smell
- Headaches
- Chronic nasal congestion
- Blurred vision
- Ringing in ears
- Hearing loss/deafness
- Other _____
- None

Breasts

- Discharge (clear? ___ bloody? ___ milky? ___)
- Lumps
- Pain
- Cancer
- Abnormal mammogram
- Reduction
- Augmentation/breast implants (saline? ___ silicone? ___)
- Other _____
- None

Genito-Urinary

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Leaking urine
- Blood in urine
- Herpes
- Other _____
- None

Hematologic

- Blood clotting disorder/blood clot
- Sickle cell Anemia
- Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusions (dates/reasons _____)
- Other _____
- None

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

Respiratory

- Shortness of breath
- Asthma
- Bronchitis
- Pneumonia
- Tuberculosis
- Bloody cough
- Other _____
- None

Neurological Problems

- Weakness/loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other _____
- None

Skin/Extremities

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Burn injury
- Moles changing in appearance
- Excess hair growth
- Other _____
- None

Cardiovascular

- Palpitations/skipped beats
- Chest pain
- Heart attack
- Stroke
- Murmurs
- High blood pressure
- Rheumatic fever
- Mitral valve prolapse
(Need antibiotics before dental procedures?)
 Yes No
- Other _____
- None

Clinician Notes (for office use only)

Part 2: Female Medical History and Information

Family History

| | <u>Living</u> | <u>Cause of Death/Age of Death</u> |
|------------------------|--|------------------------------------|
| • Mother No _____ | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> _____ |
| • Father | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____ |
| • Brother(s) | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____ |
| | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____ |
| • Sister(s) | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____ |
| | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____ |
| • Maternal Grandmother | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____ |
| • Maternal Grandfather | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____ |
| • Paternal Grandmother | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____ |
| • Paternal Grandfather | <input type="checkbox"/> Yes – age _____ | <input type="checkbox"/> No _____ |

Disorders in Your Family

| | <u>Relationship to You</u> | | |
|-----------------------------|--|--|-------------------------------------|
| • Breast Cancer | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Ovarian Cancer | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Colon Cancer | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Other Cancer _____ | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Diabetes | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Thyroid problems | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Heart Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Blood clots | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Obesity | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Psychiatric problems | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Tuberculosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Endometriosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Infertility | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Menopause before age 40 | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Birth defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Cystic Fibrosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Tay Sachs Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Canavan Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Bloom Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Gauchier Disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Niemann-Pick disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Fanconi Anemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Familial Dysautonia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Muscular Dystrophy | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Neurologic (brain/spine) | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Neural tube defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Bone/skeletal defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Dwarfism | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Mental Retardation | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Developmental Delay | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Polycystic kidney disease | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Heart defect from birth | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Downs Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Other chromosomal defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Marfan Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Hemophilia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Sickle Cell Anemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Thalassemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Galactosemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Deafness/Blindness | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Color Blindness | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| • Hemochromatosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| | <input type="checkbox"/> None of the above | <input type="checkbox"/> Other (specify) _____ | |

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

What is your Ancestry?

- African-American
- American Indian/Native American
- Ashkenazi Jewish
- Asian American
- Cajun/French Canadian
- Eastern European
- Hispanic/Caribbean
- Middle Eastern
- Northern European
- Southern European
- Other (specify _____)

Have you been screened for:

Cystic Fibrosis ___yes ___no
 Sickle Cell Anemia ___yes ___no
 Tay Sachs Disease ___yes ___no
 Thalassemia ___yes ___no

Are you and your partner
 related by blood? ___yes ___no

Part 2: Female Medical History and Information

Infertility History

- Have you had any prior infertility testing or treatment elsewhere? No Yes
- How long have you been having unprotected intercourse? ___ months ___ years
From: ___/___/___ to ___/___/___

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

Prior Tests (check all that apply)

- Day 3 blood test for FSH level (date _____/result _____)
- Thyroid blood test (date _____/result _____)
- Prolactin blood test (date _____/result _____)
- Progesterone blood test (date _____/result _____)
- Basal Body Temperature chart (date _____/result _____)
- Ovulation test kits (date _____/result _____)
- Uterine evaluation (HSG/HSC/SHG) (date _____/result _____)
- Hysteroscopy surgery (date _____/result _____)
- Laparoscopic surgery (date _____/result _____)

| | # of cycles | Dates (mo/yr) (mo/yr) From ___/___ to ___/___ | Outcome |
|---|-------------|--|--|
| <input type="checkbox"/> Intrauterine insemination: | _____ | From ___/___ to ___/___ | _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant |
| <input type="checkbox"/> Clomiphene citrate with timed intercourse: maximum # tablets per day? ____ | _____ | From ___/___ to ___/___ | _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant |
| <input type="checkbox"/> Clomiphene citrate with insemination: maximum # tablets per day? ____ | _____ | From ___/___ to ___/___ | _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant |
| <input type="checkbox"/> Daily fertility drug injections with insemination: maximum # vials per day? ____ | _____ | From ___/___ to ___/___ | _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant |
| <input type="checkbox"/> Completed in vitro fertilization cycle(s): 1. # eggs ___ # embryos transferred ___ # frozen ___ 2. # eggs ___ # embryos transferred ___ # frozen ___ 3. # eggs ___ # embryos transferred ___ # frozen ___ 4. # eggs ___ # embryos transferred ___ # frozen ___ | _____ | _____/_____ _____/_____ _____/_____ _____/_____ | _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant |
| <input type="checkbox"/> Frozen embryo transfers: 1. # embryos transferred ___ 2. # embryos transferred ___ 3. # embryos transferred ___ 4. # embryos transferred ___ | _____ | _____/_____ _____/_____ _____/_____ _____/_____ | _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant _Pregnant:_Delivered_Ectopic_Miscarriage_Not Pregnant |
| <input type="checkbox"/> Cancelled in vitro fertilization attempt(s): | _____ | | |
| <input type="checkbox"/> Any other prior treatment (describe): _____ | | | |

Prior Treatment (check all that apply):

Additional information/complications: _____

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. _____
- Do you see a counselor? No Yes – For how long? _____ How often? _____
- List any antidepressant/antianxiety medications you are currently taking. _____
Describe any emotional, marital or sexual problems caused by your infertility. _____

Patient Signature _____ Date _____

I confirm that I have reviewed this form and all the information entered on this form is true to the best of my knowledge.

Clinician Signature _____ Date _____

Part 3: Male Medical History and Information

Medical-Surgical History

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

- Have you been evaluated by an urologist? No Yes
- Have you previously fathered a pregnancy?
If yes, with current partner? No Yes
with previous partner? No Yes- # _____
No Yes- # _____
- Have you had a semen analysis? No Yes → count motility morphology
- Were the results of the semen analysis abnormal? No Yes → count motility morphology
- Do you have difficulty with erections? No Yes
- Have you ever been told that you have retrograde ejaculation (ejaculation of sperm into the bladder)? No Yes
- Have you ever had any of the following sexually transmitted diseases or pelvic infections? (check all that apply) None
Chlamydia - date _____ Gonorrhea - date _____ Herpes - date _____ Genital warts/HPV - date _____
Syphilis - date _____ HIV/AIDS - date _____ Hepatitis - date _____ Other - date _____
- Have you had a history of undescended testicles? No Yes → one both
- Do you have scrotal or testicular pain? No Yes
- Did you have the mumps after puberty? No Yes
- Have you had a prior injury to your testicles requiring hospitalization?
If yes, please describe _____
- Have you been diagnosed with any of the following diseases? (check all that apply)
Diabetes Mellitus Cancer - What type? _____
Prostatic infections Other neurologic problems _____
Multiple Sclerosis Urinary infections
High blood pressure
If yes, any medications? No Yes - specify _____
- Have you had a fever in the last 3 months? No Yes
- Have you had a vasectomy? No Yes
If yes, date _____
- Have you had a vasectomy reversal? No Yes
If yes, date _____
- Have you had surgery for a varicocele repair? No Yes
- Have you had hernia surgery? No Yes
- Did you undergo any bladder or penis surgery as a child? No Yes
- Are you exposed to prolonged heat in the workplace? No Yes
- Are you exposed to any radiation or harmful chemicals in the workplace? No Yes
- Have you had chemotherapy for cancer? No Yes
- Are you allergic to any medications? No Yes
If yes, please specify _____
- List your current medications: _____
- List any current medical problems: _____

Social History

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? _____ None
- Have you smoked cigarettes?
Do you still smoke? Never Yes- How many/day? _____ How many years? _____
No - when did you quit (year)? _____ Yes
- Do you drink alcohol?
Beer - # per week _____ Wine - # per week _____ Liquor - # per week _____
- Do you use marijuana, cocaine or any other recreational drugs? No Yes - describe _____
- Do you exercise? No Yes - describe _____
- Are you aware of any radiation exposures other than X-rays? No Yes - describe _____
- Do you use hot tubs regularly? No Yes

Part 3: Male Medical History and Information

Name: _____
(Please Print)

Date of Birth: _____
(MM/DD/YYYY)

Family History

Living Cause of Death/Age of Death

- Mother Yes – age _____ No _____
- Father Yes – age _____ No _____
- Brother(s) Yes – age _____ No _____
- Sister(s) Yes – age _____ No _____
- Maternal Grandmother Yes – age _____ No _____
- Maternal Grandfather Yes – age _____ No _____
- Paternal Grandmother Yes – age _____ No _____
- Paternal Grandfather Yes – age _____ No _____
- Did your mother take DES during pregnancy to prevent miscarriage?
 Yes No Don't Know
- Have any of your immediate family members had difficulty conceiving a child?
 Yes No
If yes, please describe _____

What is your Ancestry?

African-American
 American Indian/Native American
 Ashkenazi Jewish
 Asian American
 Cajun/French Canadian
 Southern European
 Other (specify _____)

Have you been screened for:

Cystic Fibrosis ___yes ___no
 Sickle Cell Anemia ___yes ___no
 Tay Sachs Disease ___yes ___no
 Thalassemia ___yes ___no

Disorders in Your Family

Relationship to You

- Cystic Fibrosis Yes _____ No Don't Know
- Tay Sachs Disease Yes _____ No Don't Know
- Canavan Disease Yes _____ No Don't Know
- Bloom Syndrome Yes _____ No Don't Know
- Gauchier Disease Yes _____ No Don't Know
- Niemann-Pick disease Yes _____ No Don't Know
- Fanconi Anemia Yes _____ No Don't Know
- Familial Dysautonomia Yes _____ No Don't Know
- Muscular Dystrophy Yes _____ No Don't Know
- Neurologic (brain/spine) Yes _____ No Don't Know
- Neural tube defects Yes _____ No Don't Know
- Bone/skeletal defects Yes _____ No Don't Know
- Dwarfism Yes _____ No Don't Know
- Mental Retardation Yes _____ No Don't Know
- Developmental delay Yes _____ No Don't Know
- Polycystic kidney disease Yes _____ No Don't Know
- Heart defect from birth Yes _____ No Don't Know
- Downs Syndrome Yes _____ No Don't Know
- Other chromosomal defects Yes _____ No Don't Know
- Marfan Syndrome Yes _____ No Don't Know
- Hemophilia Yes _____ No Don't Know
- Sickle Cell Anemia Yes _____ No Don't Know
- Thalassemia Yes _____ No Don't Know
- Galactosemia Yes _____ No Don't Know
- Deafness/Blindness Yes _____ No Don't Know
- Color Blindness Yes _____ No Don't Know
- Hemochromatosis Yes _____ No Don't Know
- None of the Above _____ Other (specify _____)

Are you and your partner related by blood? ___yes ___no

Spouse/Male partner's Signature _____ Date _____

I confirm that I have reviewed this form and all the information entered on this form is true to the best of my knowledge.

Clinician Signature _____ Date _____