UC Health Center for Reproductive Health

UC Health Physician Office South
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Male History Form

(Complete with your male partner if applicable)

1. IDENTIFYING INFORMATION

Date this form was completed _____/_____/_____

Name ____

DOB _____/_____/_____ Age _______________

2. PREGNANCY HISTORY (that you have been responsible for) ☐ **None**

	Date	Mis-carriage?	Elective Abortion?	Months to conceive?	Infertility Treatment?	Weight and sex?	Complications?
1.							
2.							
3.							

3. OPERATIONS AND HOSPITALIZATIONS

	Date	Reason and type of surgery	Where	Physician
1.				
2.				
3.				

4. MEDICAL HISTORY

Do you have or have you had?

- ❑ Cancer
- ❑ Diabetes
- ❑ Hypertension
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Mitral valve prolapse
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Hepatitis / liver disorder
- ❑ Gall bladder problems
- ❑ Ulcers
- ❑ Colitis / enteritis
- ❑ Kidney disorder
- ❑ Rubella
- ❑ Multiple sclerosis
- ❑ Mumps
- ❑ Prostatic infections
- ❑ Urinary infections
- ❑ Serious injury / accident
- ❑ Blood transfusion
- ❑ Psychiatric disorder
- ❑ Seizures
- ❑ Stroke
- ❑ Blood clots
- ❑ Anemia
- ❑ Bleeding disorder
- ❑ Thyroid disorder
- ❑ Recent immunization

Any medical problem not listed above (please list type, dates, treatments)

1. ____
2. ____

5. MEDICATIONS *List all prescriptions and over-the-counter drugs used during the past year.*

	Date	Dose and frequency	From when to when	Reason
1.				
2.				
3.				

6. ALLERGIES

Drug or substance   Reaction

1. ______________________:______________________________

2. ______________________:______________________________

7. OTHER HISTORY

Your occupation:..

Cigarettes - packs smoked per day:..

Other drugs - type and amount:..

Ever used intravenous drugs? ❑ yes ❑ no

Alcohol - type and number per week:. . . . .

Marijuana - amount:..

Jacuzzi ❑ yes ❑ no IF yes, #/week:..

Radiation exposure: ❑ yes ❑ no

8. UROLOGIC HISTORY (If applicable)

Have you been evaluated by a urologist? ❑ Yes ❑ No

Are you able to ejaculate inside your partner's vagina? ❑ Yes ❑ No

Do you have retrograde ejaculation of sperm into the bladder? ❑ Yes ❑ No

Have you had any of the following sexually transmitted diseases or severe testicular pain?

❑ Yes (check all that apply) ❑ No

❑ Chlamydia – date _______ ❑ Gonorrhea – date ________ ❑ Herpes – date ________ ❑ Genital Warts/HPV – date ________

❑ Syphilis – date ________ ❑ HIV/AIDS – date _______ ❑ Hepatitis – date _______ ❑ Other

Have you had a history of undescended testicles? ❑ Yes – One side ______ Both ______ ❑ No

Have you ever had torsion/twisting of the testicles? ❑ Yes ❑ No

Did you have mumps after puberty? ❑ Yes ❑ No

Have you had injury to your testicles requiring an ER visit or hospitalization? ❑ Yes ❑ No

Have you had fever (>101° F) in the past 3 moths? ❑ Yes ❑ No

Have you had a vasectomy? ❑ Yes – date ________ ❑ No

If yes, have you had a vasectomy reversal? ❑ Yes – date ________ ❑ No

Have you had varicocele surgery? ❑ Yes ❑ No

Have you had hernia surgery? ❑ Yes ❑ No

Have you had other surgery to the scrotum or groin area? ❑ Yes ❑ No

Are you exposed to prolonged heat in the workplace? ❑ Yes ❑ No

Are you exposed to harmful chemicals or fumes in the workplace? ❑ Yes ❑ No

Do you use hot tubs regularly? ❑ Yes ❑ No

Have any of your immediate family members had difficulty conceiving a child? ❑ Yes ❑ No

9. FAMILY HISTORY / GENETIC HISTORY

	Mother	Father	Brothers: #	Sisters: #	Children: #	Other
Cancer (type)						
Diabetes						
Hypertension						
High Cholesterol						
Heart Disease						
Stroke						

10. ETHNICITY **Data will be used for genetic testing recommendation purposes*

❑ Caucasian ❑ Hispanic ❑ Asian ❑ African American ❑ Other (______________________________)

Do you or anyone in either family have?

❑ Neural tube defects/spina bifida/anencephaly
❑ Cystic fibrosis
❑ Tay-Sachs disease
❑ Chromosomal disorder
❑ Muscular dystrophy
❑ Sickle cell disease or trait
❑ Genetic / inherited disorder

❑ Thalassemia
❑ Huntington chorea
❑ Hemophilia
❑ Baby with birth defects
❑ Down syndrome
❑ Mental retardation / fragileX
❑ Hormonal disorder
❑ Infertility

❑Hydrocephalus
❑Epilepsy or seizures
❑Kidney disease
❑Mental illness
❑Stillbirth
❑Phenylketonuria
❑Neurofibromatosis
❑Myotonic dystrophy

❑3 or more miscarriages
❑Diabetes

❑ Any birth defects? **❑ Any inherited disorders?**

Please explain a "Yes" answer to any of the above____

____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on your ethnicity. Are you: African-American ❑ Yes ❑ No

Ashkenazi Jewish ❑ Yes ❑ No Mediterranean/Asian/French Canadian ❑ Yes ❑ No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

11. HISTORY OF FERTILITY THERAPY (Fill out, if applicable)

Have you been treated for infertility previously? ❑ YES ❑ NO If yes, who was your physician? ……………………………..
What cause of infertility was diagnosed? ……………………………………………………………………………………………
What medications have you taken for infertility? ………………………………………………..
Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

❑ Semen Analysis When _____/_____/_____ Results ………………………………………….
❑ Chromosomes When _____/_____/_____ Results ………………………………………….
❑ Genetic screening When _____/_____/_____ Results ………………………………………….
❑ OTHER____

PARTNER'S SIGNATURE **DATE**

____

I confirm that I have reviewed the above information.

PHYSICIAN'S SIGNATURE **DATE**

____

Welcome and we look forward to working with you.
Please write down any specific concerns you want to review at your visit.

Thank you - The UC Center for Reproductive Health Team