West Coast | Urology PALETZ AGATSTEIN UROLOGY MEDICAL GROUP, INC

MALE INFERTILITY WORKSHEET

FULL NAME	DATE OF BIRTH	TODAY'S DATE

Age of Patient _____ Age of Partner _____

Years Married _____ Years trying to conceive _____

Previous pregnancy with wife/partner: Live Births _____ Miscarriages _____ Abortions _____

Previous pregnancy with someone other than wife/partner: Live Births _____ Miscarriages _____ Abortions _____

Has your wife/partner ever had pregnancies with another man:

Details _____

Has your wife/partner undergone recent gynecologic evaluation for infertility:

Details _____

MEDICAL HISTORY

Have you had any of the following illnesses?

- ☐ Arthritis
- ☐ Cancer (Type and Treatment) _____
- _____
- _____
- _____
- ☐ Chronic Lung Disease/Bronchitis
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Inflammatory Bowel Disease
- ☐ Kidney Failure
- ☐ Liver Problems
- ☐ Mumps Orchitis
- ☐ Neurologic Disorder
- ☐ Psychiatric Disease
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Spine/Back Injury
- ☐ Thyroid Disease
- ☐ Tuberculosis

SURGERY

Have you had any of the following operations?

- ☐ Bladder surgery
- ☐ Hydrocele repair
- ☐ Hypospadias repair
- ☐ Inguinal Hernia
- ☐ Prostate surgery
- ☐ Spermatocele repair
- ☐ Testicular biopsy
- ☐ Undescended testis
- ☐ Urethral stricture
- ☐ Varicocele repair
- ☐ Vasectomy
- ☐ Vasovasostomy

Any other surgery: _____

_____

MEDICATIONS

Have you taken any of the following medications?

- ☐ Acyclovir (Zovirax)
- ☐ Cimetidine (Tagamet)
- ☐ Clomid
- ☐ Cortisone
- ☐ Cyclosporine
- ☐ Digoxin
- ☐ Dilantin
- ☐ hCG Injections
- ☐ Ketoconazole
- ☐ Nitrofurantoin
- ☐ Prednisone
- ☐ Procardia
- ☐ Ranitidine (Zantac)
- ☐ Spirinolactone
- ☐ Sulfasalazine
- ☐ Testosterone

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REVIEW OF SYSTEMS

1	Do you frequently get colds, upper respiratory tract infections, sinus infections?	Yes ☐ No ☐
2	Do you have significant problems with your sense of smell?	Yes ☐ No ☐
3	Have you noticed any problems with your peripheral vision?	Yes ☐ No ☐
4	Have you noticed any secretions or tenderness in your breasts?	Yes ☐ No ☐
5	Do you have any testicular pain or discomfort?	Yes ☐ No ☐
6	Have you had a high fever in the past 6 months?	Yes ☐ No ☐
7	Have you had a urinary tract infection/prostatitis?	Yes ☐ No ☐
8	Have you had epididymitis?	Yes ☐ No ☐
9	Have you had testicular torsion?	Yes ☐ No ☐
10	Have you had trauma to one or both testes?	Yes ☐ No ☐
11	Have you had any sexually transmitted diseases? (Chlamydia, gonorrhea, herpes, syphilis, HIV)	Yes ☐ No ☐
12	Have you had a heavy exposure to toxins, poisons, pesticides, radiation, or solvents?	Yes ☐ No ☐
13	Do you take long baths, saunas, steam baths, or Jacuzzis?	Yes ☐ No ☐
14	Do you put your laptop computers and cell phones near the groin?	Yes ☐ No ☐
15	Do you smoke? *If so*, how many packs a day? _____	Yes ☐ No ☐
16	Have you smoked marijuana heavily in the past?	Yes ☐ No ☐
17	How many drinks do you have in an average week? _____	
18	Do you drink more than 2-3 drinks in a 24-hour period?	Yes ☐ No ☐
19	Do you currently use, or have you used extensively use any of the following substances? Cocaine, LSD, amphetamines, Heroin	Yes ☐ No ☐
20	Have you ever used steroids for bodybuilding?	Yes ☐ No ☐
21	Do you take vitamins or supplements?	Yes ☐ No ☐
22	Anyone in your family wth cystic fibrosis?	Yes ☐ No ☐

SEXUAL HISTORY

1	Do you ejaculate during intercourse?	Yes ☐ No ☐
2	Do you ejaculate into your partner's vagina?	Yes ☐ No ☐
3	Are you able to achieve an adequate erection for intercourse?	Yes ☐ No ☐
4	Do you use any lubricants for intercourse?	Yes ☐ No ☐
5	Does your partner usually lie down for at least 30 minutes after intercourse?	Yes ☐ No ☐
6	Do you have intercourse daily or every other day when your partner is ovulating?	Yes ☐ No ☐
7	Do you know when your partner is ovulating?	Yes ☐ No ☐

Please add any information that you believe might be helpful _____