Male Partner's History Form (if applicable)

North Shore LIJ The Center for Human Reproduction

PATIENT'S NAME: _____

TODAY'S DATE: _____

MALE PATIENT'S HISTORY FORM

NORTH SHORE UNIVERSITY HOSPITAL

DIVISION OF HUMAN REPRODUCTION

TODAY'S DATE:

YOUR NAME: AGE: BIRTH DATE:
BIRTH PLACE:
CELL PHONE:

YOUR ADDRESS: HOME PHONE:

YOUR OCCUPATION: BUS. TEL:
EMAIL:

YOUR EMPLOYER: MARITAL STATUS:

[ ] SINGLE [ ] DIVORCED
[ ] MARRIED [ ] WIDOWED

RELIGION:

PARTNER'S - MEDICAL HISTORY

YOUR PARTNER: AGE:

YOUR PARTNER'S OCCUPATION:

YOUR PARTNER'S EMPLOYER:

BUS.ADDRESS:

BUS.TEL: CELL:

RELIGION:

REFERRED BY:
MD: RELATIVE./FRIEND:

ADDRESS: ADDRESS:

YOUR PRIMARY INSURANCE:

CARD.NO: GROUP NO.:

ALL PREVIOUS OCCUPATIONS:

LIST ALL STATES OR COUNTRIES IN WHICH YOU HAVE LIVED:

EDUCATION: PLEASE CIRCLE THE LAST GRADE YOU COMPLETED

HIGH SCHOOL 1 2 3 4
COLLEGE 1 2 3 4 DEGREES POST GRAD _____YRS

DATE OF LAST PHYSICAL EXAM:

CHIEF COMPLAINTS: PLEASE LIST ALL SYMPTOMS YOU HAVE NOW
1._____
2._____
3._____

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_____

FAMILY HISTORY	AGE	IF LIVING, What is their health?	AGE AT DEATH	IF DECEASED, CAUSE
FATHER				
MOTHER				
BROTHER OR SISTER 1				
2				
3				
4				
5				
HUSBAND OR WIFE				
SON OR DAUGHTER 1				
2				
3				
4				
5				
6				

HAS ANY BLOOD RELATIVES HAD		PLEASE CIRCLE WHO
CANCER	NO	YES
TUBERCULOSIS	NO	YES
DIABETES	NO	YES
HEART TROUBLE	NO	YES
HIGH BLOOD PRESSURE	NO	YES
STROKE	NO	YES
EPILEPSY	NO	YES
MENTAL ILLNESS	NO	YES
MISCARRIAGE	NO	YES
INFERTILITY	NO	YES
CONGENITAL DEFORMITIES	NO	YES

PERSONAL HISTORY

ILLNESS: HAVE YOU HAD (PLEASE CIRCLE ALL ANSWERS NO OR YES)

PNEUMONIA	NO	YES
RHEUMATIC FEVER OR HEART DISEASE	NO	YES
ARTHRITIS, LUPUS	NO	YES
ANY BONE OR JOINT DISEASE	NO	YES
NEUROLOGICAL DISEASE	NO	YES
ASTHMA	NO	YES
HIVES OR ECZEMA	NO	YES
FREQUENT COLDS OR SORE THROAT	NO	YES
HEPATITUS B or C	NO	YES
HIV or AIDS	NO	YES
GONORRHEA,SYPHILIS,HERPES	NO	YES
ANEMIA OR JAUNDICE	NO	YES
EPILEPSY	NO	YES
MIGRAINE HEADACHES	NO	YES
TUBERCULOSIS	NO	YES
DIABETES	NO	YES
HIGH PRESURE	NO	YES
PSYCHIATRIC ILLNESS	NO	YES
FREQUENT INFECTIONS	NO	YES
ANY OTHER DISEASE	NO	YES

(Please indicate what type of disease)

ALLERGIES: ARE YOU ALLERGIC TO:

PENICILLIN OR SULFA	NO	YES
ASPIRIN,CODEINE OR MORPHINE	NO	YES
MYCINS OR OTHER ANTIBIOTICS	NO	YES
IODINES	NO	YES
ANY OTHER DRUG	NO	YES
LATEX	NO	YES
ADHESIVE TAPE	NO	YES
TETANUS ANTIOXIN OR SERUMS	NO	YES

TRANSFUSIONS: HAVE YOU EVER HAD

BLOOD OR PLASMA TRANSFUSION NO YES

WEIGHT: NOW_____ONE YEAR AGO_____
MAX._____ WHEN_____ HEIGHT_____

Please review the section you have just completed and wherever you answered "YES", fill in the year (guess if necessary); where there is more than one illness listed on the line, circle the ones you had. For example: CHICKEN POX or MUMPS: NO YES

SURGERY: HAVE YOU HAD:
ANY OPERATIONS (GIVE DETAILS) NO YES

Give DETAILS below of all hospitalizations for Surgery or illness including date of surgery/illnes, name and address of Doctor and Hospital.

HAVE YOU EVER BEEN ADVISED TO HAVE ANY SURGICAL OPERATION WHICH HAS NOT BEEN DONE? NO YES WHAT: _____

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.
INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

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PATIENT'S NAME: _____ **MALE PATIENT'S HISTORY FORM**

TODAY'S DATE: _____

Page 2 PARTNER'S MEDICAL HISTORY

Have you been treated for any of the following conditions? [ ] Yes [ ] No

[ ] diabetes [ ] chronic respiratory disease [ ] inflammatory bowel disease
[ ] tuberculosis [ ] mumps orchitis [ ] seizure disorder

Have you ever used any of the following medications? [ ] Yes [ ] No

[ ] prednisone [ ] cortisone [ ] sulfasalazine [ ] nitrofurantoin
[ ] cyclosporine [ ] cimetidine [ ] spironolactone [ ] nitdazole
[ ] procardia [ ] ketoconazole [ ] dilantin [ ] digoxin

Have you ever had any of the following conditions? [ ] Yes [ ] No

[ ] chlamydia [ ] gonorrhea [ ] syphilis [ ] herpes
[ ] tuberculosis

Have you ever had any of the following operations? [ ] Yes [ ] No

[ ] hernia repair [ ] varicocelectomy [ ] orchiopexy [ ] urethral stricture
[ ] prostatectomy [ ] vasectomy [ ] hypospadias [ ] bladder neck
[ ] hydrocelectomy [ ] testis biopsy

Have you ever been treated for cancer? [ ] Yes [ ] No
Are you taking medications now? If so, please list the medication and dosage below [ ] Yes [ ] No
Have you had a high fever in the past 6 months? [ ] Yes [ ] No
Have you ever had a urinary tract infection? [ ] Yes [ ] No
Have you ever had epididymitis? [ ] Yes [ ] No
Have you ever had prostatitis? [ ] Yes [ ] No
Have you ever had testicular torsion? [ ] Yes [ ] No
Have you ever had a serious injury to one or both testes? [ ] Yes [ ] No
Have you ever been treated for undescended testis? [ ] Yes [ ] No

HABITS: ..... Do You:			LIST ANY DRUGS OR MEDICATIONS YOU TAKE REGULARLY OR FREQUENTLY
SLEEP WELL?	NO	YES	
Alcoholic beverages?	NO	YES	
(everyday?)	NO	YES	
SMOKE?	NO	YES	
(If so, how much?)			
DRUG USE?	NO	YES	
(if so, which drugs)			
EXERCISE ENOUGH?	NO	YES	
IS YOUR DIET WELL BALANCED?	NO	YES	

MARITAL DATES

Prior marriage? [ ] NO [ ] YES, (Dates): _____

Was pregnancy achieved? [ ] NO [ ] YES **If yes, when?** _____

Is sex entirely satisfactory? [ ] NO [ ] YES

Other proof of fertility? _____

Estimate frequency of coitus (sexual intercourse) per month? _____

Any difficulty with ejaulation? [ ] NO [ ] YES

Any difficulty with erection? [ ] NO [ ] YES

INDICATE THE INFORMATION FOR ANY OF THE FOLLOWING STUDIES WHICH YOU HAVE HAD

	DATE	RESULT	DOCTOR or WHERE DONE
SEMEN ANALYSIS:			
HORMONE TESTS:			
MEDICINES GIVEN:			
OTHER TESTS:			