

# Male Partner's History Form

(if applicable)

# Northwell Health Fertility Male Patient's History Form



**PATIENT'S NAME:** \_\_\_\_\_  
 LAST NAME FIRST NAME

**TODAY'S DATE:** \_\_\_\_\_

**NAME (FORMERLY):** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **CELL PHONE:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_ **BUS. TEL:** \_\_\_\_\_

**YOUR EMPLOYER:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**ETHNICITY:** \_\_\_\_\_ **RELIGION:** \_\_\_\_\_

**MARITAL STATUS:**  DIVORCED  
 SINGLE  WIDOWED  
 MARRIED  
 SAME SEX COUPLE

**PARTNER:**

**AGE:** \_\_\_\_\_

**PARTNER'S OCCUPATION:** \_\_\_\_\_

**PARTNER'S EMPLOYER:** \_\_\_\_\_

**BUS. ADDRESS:** \_\_\_\_\_

**BUS. TEL:** \_\_\_\_\_

**ETHNICITY:** \_\_\_\_\_

**REGLIGION:** \_\_\_\_\_

<b>REFERRED BY:</b> MD: _____ ADDRESS: _____	<b>RELATIVE/FRIEND:</b> ADDRESS: _____	<b>YOUR PRIMARY INSURANCE:</b> CARD NUMBER: _____ GROUP NUMBER: _____
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<b>ALL PREVIOUS OCCUPATIONS:</b>	<b>LIST ALL STATES OR COUNTRIES IN WHICH YOU HAVE LIVED:</b>
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**EDUCATION:** PLEASE INDICATE THE LAST GRADE YOU COMPLETED

HIGH SCHOOL 1 2 3 4  POST GRAD. \_\_\_\_\_ YRS.  
 COLLEGE 1 2 3 4 DEGREES:

DATE OF LAST PHYSICAL EXAM: _____ CHIEF COMPLAINTS: (PLEASE LIST ALL SYMPTOMS YOU HAVE NOW) 1. _____ 2. _____ 3. _____ 4. _____	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.? <input type="checkbox"/> NO <input type="checkbox"/> YES _____ _____ _____ _____
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# Northwell Health Fertility

## Male Patient's History Form



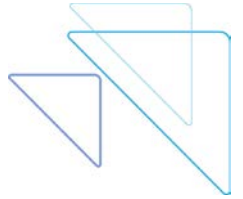
PATIENT'S NAME: \_\_\_\_\_  
 LAST NAME FIRST NAME

TODAY'S DATE: \_\_\_\_\_

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				

HAVE ANY BLOOD RELATIVES HAD:	WHO:	
CANCER.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
TUBERCULOSIS.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
DIABETES.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
HEART TROUBLE.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
HIGH BLOOD PRESSURE.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
STROKE.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
EPILEPSY.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
MENTAL ILLNESS.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
MISCARRIAGE.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
INFERTILITY.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
CONGENITAL DEFORMITIES.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____
GENETIC DISEASES.....	<input type="checkbox"/> NO	<input type="checkbox"/> YES _____

# Northwell Health Fertility Male Patient's History Form

**PERSONAL HISTORY**

**PATIENT'S NAME:** \_\_\_\_\_  
LAST NAME FIRST NAME

**TODAY'S DATE:** \_\_\_\_\_

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

MEASLES OR GERMAN MEASLES	<input type="checkbox"/> NO <input type="checkbox"/> YES	ANEMIA OR JAUNDICE	<input type="checkbox"/> NO <input type="checkbox"/> YES
CHICKEN POX OR MUMPS	<input type="checkbox"/> NO <input type="checkbox"/> YES	EPILEPSY	<input type="checkbox"/> NO <input type="checkbox"/> YES
PNEUMONIA OR PLEURISY	<input type="checkbox"/> NO <input type="checkbox"/> YES	MIGRAINE HEADACHES	<input type="checkbox"/> NO <input type="checkbox"/> YES
RHEUMATIC FEVER OR HEART DISEASE	<input type="checkbox"/> NO <input type="checkbox"/> YES	TUBERCULOSIS	<input type="checkbox"/> NO <input type="checkbox"/> YES
ARTHRITIS, LUPUS	<input type="checkbox"/> NO <input type="checkbox"/> YES	DIABETES	<input type="checkbox"/> NO <input type="checkbox"/> YES
ANY BONE OR JOINT DISEASE	<input type="checkbox"/> NO <input type="checkbox"/> YES	HIGH BLOOD PRESSURE	<input type="checkbox"/> NO <input type="checkbox"/> YES
NEUROLOGICAL DISEASE	<input type="checkbox"/> NO <input type="checkbox"/> YES	PSYCHIATRIC ILLNESS	<input type="checkbox"/> NO <input type="checkbox"/> YES
SCIATICA	<input type="checkbox"/> NO <input type="checkbox"/> YES	ASTHMA	<input type="checkbox"/> NO <input type="checkbox"/> YES
KIDNEY DISEASE	<input type="checkbox"/> NO <input type="checkbox"/> YES	HIVES, ECZEMA, PSORIASIS	<input type="checkbox"/> NO <input type="checkbox"/> YES
CANCER	<input type="checkbox"/> NO <input type="checkbox"/> YES	FREQUENT INFECTIONS	<input type="checkbox"/> NO <input type="checkbox"/> YES
HIV OR AIDS	<input type="checkbox"/> NO <input type="checkbox"/> YES	ANY OTHER DISEASE	<input type="checkbox"/> NO <input type="checkbox"/> YES
HEPATITIS B OR C	<input type="checkbox"/> NO <input type="checkbox"/> YES	(Please indicate what type of disease)	
GONORRHEA, SYPHILIS, HERPES, CHLAMYDIA, OR HPV	<input type="checkbox"/> NO <input type="checkbox"/> YES		
STROKE	<input type="checkbox"/> NO <input type="checkbox"/> YES		
HEART TROUBLE	<input type="checkbox"/> NO <input type="checkbox"/> YES		

**ALLERGIES: ARE YOU ALLERGIC TO (PLEASE INDICATE ALL ANSWERS NO OR YES)**

PENICILLIN OR SULFA	<input type="checkbox"/> NO <input type="checkbox"/> YES	WEIGHT: NOW _____ ONE YEAR AGO _____
ASPIRIN, CODEINE OR MORPHINE	<input type="checkbox"/> NO <input type="checkbox"/> YES	
MYCINS OR OTHER ANTIBIOTICS	<input type="checkbox"/> NO <input type="checkbox"/> YES	MAX. _____ WHEN _____
IODINES	<input type="checkbox"/> NO <input type="checkbox"/> YES	
ANY OTHER DRUG	<input type="checkbox"/> NO <input type="checkbox"/> YES	HEIGHT _____
ADHESIVE TAPE	<input type="checkbox"/> NO <input type="checkbox"/> YES	
LATEX	<input type="checkbox"/> NO <input type="checkbox"/> YES	
TETANUS ANTIOXIN OR SERUMS	<input type="checkbox"/> NO <input type="checkbox"/> YES	
<b>TRANSFUSIONS: HAVE YOU EVER HAD</b>		
BLOOD OR PLASMA TRANSFUSION	<input type="checkbox"/> NO <input type="checkbox"/> YES	

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, indicate the ones you had. For example, CHICKEN POX OR MUMPS.....NO YES

DO YOU WISH INFORMATION ON ADVANCED DIRECTIVES? NO YES GIVEN: \_\_\_\_\_

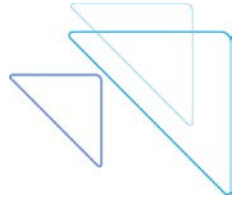
HAVE YOU EVER BEEN ADVISED TO HAVE ANY SURGICAL OPERATION WHICH HAS NOT BEEN DONE?  
NO YES WHAT: \_\_\_\_\_

**NOTE:**

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.

# Northwell Health Fertility

## Male Patient's History Form



**PATIENT'S NAME:** \_\_\_\_\_  
 LAST NAME FIRST NAME

**TODAY'S DATE:** \_\_\_\_\_

Have you ever 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  nifedipine  
 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 structure  
 prostatectomy  vasectomy  hypospadias  bladder neck  
 hydrocelectomy  testis biopsy

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

**HABITS DO YOU:**

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  
 Diet well balanced?  No  Yes

**LIST ANY DRUGS OR MEDICATIONS YOU TAKE REGULARLY OR FREQUENTLY**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MARITAL DATES**

Prior marriage?  No  Yes, Dates: \_\_\_\_\_ Was pregnancy achieved?  No  Yes  
 If sex entirely satisfactory?  No  Yes Other proof of fertility? \_\_\_\_\_  
 If yes, when? \_\_\_\_\_

Estimate of frequency of coitus (sexual intercourse) per month? \_\_\_\_\_

Difficulty with ejaculation?  No  Yes  
 Difficulty with erection?  No  Yes

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**PATIENT'S NAME:** \_\_\_\_\_  
LAST NAME FIRST NAME

**TODAY'S DATE:** \_\_\_\_\_

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:			