Northwell Health Fertility

Male Partner's History Form

(if applicable)

Northwell Health®

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:

REFERRED BY: MD: ADDRESS:	RELATIVE/FRIEND: ADDRESS:	YOUR PRIMARY INSURANCE: CARD NUMBER: GROUP NUMBER:

ALL PREVIOUS OCCUPATIONS:	**LIST ALL STATES OR COUNTRIES IN WHICH YOU HAVE LIVED:**

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.? □ NO □YES

_____
_____
_____
_____

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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.....	☐ 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 _____
GENETIC DISEASES.....	☐ NO	☐YES _____

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

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

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
ADHESIVE TAPE	☐NO ☐YES
LATEX	☐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, 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.

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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 and of the following medications? □ Yes □ No
□ predinisone □ cortisone □ sulfasalazine □ nitrofurantoin
□ cyclosporine □ cimetidine □ spironolactone □ niridazole
□ Procardia □ ketoconazole □ Dilantin □ digoxin

Have you ever had any of the following conditions? □ Yes □ No
□ chlamyida □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 yes, when? _____

Is sex entirely satisfactory? □ No □ Yes Other proof of fertility? _____
_____

Estimate of frequency of coitus (sexual intercourse) per month? _____
Difficulty with ejaculation? □ No □ Yes
Difficulty with erection? □ No □ Yes

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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:			