Northwestern Medicine®
Fertility and Reproductive Medicine

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HEALTH HISTORY - MEN

Date:_____

Last Name _____ First Name _____ Middle Initial _____ Age _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referring Physician _____ Office Phone _____ Your Religion _____

FAMILY HISTORY

☐ Family History Unknown ☐ Adopted

Father: □ Alive - Age:_____ □ Deceased - Cause:_____
Mother: □ Alive - Age:_____ □ Deceased - Cause:_____
Sister(s): #_____ Age(s):_____
Brother(s): #_____ Age(s):_____

MEDICAL HISTORY (CURRENT & PAST)

Height:_____ Current Weight:_____ Highest Weight:_____ Lowest Weight:_____
Allergies:_____ Reaction:_____

Current Medications/Vitamins/Supplements (Please include dose):

_____
_____

Surgical History (Please include name of surgery, date and where it was performed):

_____
_____

Current Use of Complementary Medicine (i.e. herbs, acupuncture, etc.):

_____

Any history of blood transfusion?..... No Yes

HISTORY OF:

Rapid or Marked Changes in Weight	No	Yes	Increased Sweating	No	Yes
Changes in Appetite	No	Yes	Painful Swallowing	No	Yes
Chronically Warm or Cold	No	Yes	Insomnia	No	Yes
Change of Voice of Hoarseness	No	Yes	Tremors	No	Yes
Fatigue	No	Yes	Loss of Hair (other than scalp)	No	Yes
Salt Craving	No	Yes	Thyroid Disease	No	Yes
Decreased Beard Growth	No	Yes	Increase in Breast Size	No	Yes
Diabetes	No	Yes	Sore Nipples	No	Yes
Heart Disease	No	Yes	Scarlet Fever	No	Yes
Rheumatic Fever	No	Yes	High Blood Pressure	No	Yes
Tuberculosis	No	Yes	Pneumonia	No	Yes
Chronic Bronchitis	No	Yes	Liver/Gall Bladder Disease	No	Yes
Cirrhosis	No	Yes	Jaundice	No	Yes
Pancreatitis	No	Yes	Arthritis	No	Yes
Auto-Immune Disease	No	Yes	Gout	No	Yes
Other Serious Chronic Disease	No	Yes	Pain/Burning with Urination	No	Yes
Discharge	No	Yes	Blood in Urine or Ejaculation	No	Yes
Waking to Void at Night	No	Yes	Non-Urological Operation	No	Yes
Increased Thirst	No	Yes	Therapeutic X-Ray Treatment	No	Yes

If You answered YES to any of the above, please explain:_____

_____

Continued on Other Side →

At what age did you begin shaving? ☐ Under 12 ☐ 12-14 ☐ 15-17 ☐ 18-20 ☐ over 20

How would you describe your beard growth? ☐ Light ☐ Medium ☐ Heavy

↳ Compared to other men in your family? ☐ Light ☐ Medium ☐ Heavy

Type of Underwear Worn: ☐ Boxer Shorts ☐ Jockeys ☐ Other:_____

Do you Smoke: ..... No Yes

↳ If Yes Please complete the following:

Which Do You Use?: ☐ Tobacco ☐ Cigars ☐ Cigarettes ☐ Pipe

How Long Have You Smoked? _____ months/years Amount Used Daily:_____

Do You Drink Alcohol? ..... No Yes

↳ If YES – How Much Do You Drink? _____

If you have any history of or currently use Marijuana/Cocaine/Crack or other addictive drugs – Please tell the physician verbally

SOCIAL HISTORY

Present means of employment:_____

How long has this type of work been performed:_____

Have you ever been employed in an occupation with sustained high temperatures? ..... No Yes

Have you ever been a professional driver or do you drive long distances as part of your job? ..... No Yes

History of recent hospitalization or prolonged bed rest? ..... No Yes

History of hot baths, sauna or steam baths? ..... No Yes

Are you an IV drug user? ..... No Yes

Have you ever had sex with an IV drug user? ..... No Yes

Have you ever had sex with a homosexual or bisexual person? ..... No Yes

Are you at risk for AIDS? ..... No Yes

Total number of sexual partners: _____

UROLOGICAL HISTORY

Are you circumcised? ..... No Yes

↳ If NO, does the foreskin retract easily? ..... No Yes

Have you ever been treated for gonorrhea, syphilis, prostatitis or infection of the testicles and/or seminal vesicles? ..... No Yes

Any history of hernia repair (including shortly after birth)? ..... No Yes

↳ If YES, when? _____

History of Mumps? ..... No Yes

↳ If YES, when? _____

History of undescended testes? ..... No Yes

History of injury to the testes? ..... No Yes

History or diagnosis of varicocele (varicose vein in scrotum)? ..... No Yes

↳ If YES, has this been treated? If so, when? _____

History of genitourinary infection? ..... No Yes

Has there been a recent change in libido or sexual drive? ..... No Yes

Do you have difficulty maintaining an erection? ..... No Yes

If applicable, do have difficulty ejaculating in the vagina? ..... No Yes

Has a doctor ever told you that you were infertile? ..... No Yes

Has a semen analysis ever been performed? ..... No Yes

↳ If YES – When?_____ Where? _____ Results? _____

Have fathered a child outside this relationship? ..... No Yes

Have you ever doubted your fertility outside this relationship? ..... No Yes

Any history of treatment to promote fertility in the past? ..... No Yes

↳ If YES, please explain: _____

Has artificial insemination ever been suggested to achieve pregnancy? ..... No Yes

↳ If YES, ☐ with YOUR Sperm? ☐ with DONOR Sperm?