Date ____________

MALE PARTNER HEALTH HISTORY

Please complete the following information to the best of your ability:

Name ____ *Height* ________ *Weight* _________

Male Reproductive History:

Have you previously fathered children? _______________

Number of children fathered with your current partner? _______________

Number of children fathered with previous partner(s)? _______________

Age of youngest child _______________

If you have previously undergone fertility evaluation/treatment, please provide your records and/or briefly detail your work-up (including the month/year of your most recent semen analysis) ____

____

____

____

Medical History:

Do you have any illnesses (particularly ongoing medical conditions for which you take take medications)? If yes, please elaborate _______________________________

____

____

Are you taking any medications (including vitamins and/or herbal medications)? If yes, please elaborate and include dose and how frequently each medication is taken

____

____

____

Have you ever had an allergic reaction to a medication? If yes, please include the medication and type of reaction _______________________________________

____

Surgical History:

Have you ever undergone any office, outpatient, or inpatient surgical procedures? If yes, please include the type and the year of the procedure(s) _________________

____

____

Social History: *Do you smoke cigarettes or use other tobacco products? If yes, please elaborate and include number of cigarettes per day or week and number of years of cigarette use*

____

Do you drink alcohol? If yes, please elaborate and include number of drinks per day or week ____

In your employment, do you have exposure to fuels, petrol-based solvents, or other chemicals? If yes, please elaborate ____

____

Family History: *(e.g. diabetes, high blood pressure, heart disease, cancer)*

Maternal illnesses ____

Paternal illnesses ____

Sibling Illnesses ____

Other relevant family history ____