Fertility Wellness Institute
NeeOo W. Chin MD

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____

Name _____ Partner's Name _____

Address _____

Telephone Number -- Day: ( ) _____ Evening: ( ) _____

Date of Birth _____Partner's Date of Birth _____Duration of Relationship _____Duration of Infertility _____

Insurance Company _____Insurance I.D. # _____

Nature of present employment (title, brief description) _____

_____

II. TRAVEL/WORK AND GENERAL BACKGROUND

All present employment -- titles, location, brief description, number of years employed:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Are you or have you ever been exposed to any of the following during employment or military service:

- ☐ Heat
- ☐ Toxic Fumes
- ☐ Other Specify: _____
- ☐ Chemicals
- ☐ Nuclear Radiation

_____

III. MEDICAL HISTORY

	YES	NO
Weight _____ Height _____ Blood Type (if known) _____		
Have you lost greater than 20 pounds of weight in the last year?.....	☐	☐
Do you follow a particular food diet or have any special dietary habits?.....	☐	☐
If yes, specify: _____		
List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and age you began:		
Exercise: _____ Hrs/Week: _____ Age_____ Exercise: _____ Hrs/Week: _____ Age_____		
Do you frequently take saunas or steam baths?	☐	☐
Have you ever had surgery in the pelvic area?.....	☐	☐
If yes, specify date and type: _____		
Have you ever received X-rays in the pelvic area for therapy or diagnosis ?.....	☐	☐
If yes, explain: _____		

Do you have or have you ever had (check all that apply):

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood Transfusions
- ☐ Breast Milky Discharge
- ☐ Breast Soreness
- ☐ Breast Tenderness
- ☐ Cancer? Specify _____
- ☐ Chlamydia
- ☐ Chronic Bronchitis
- ☐ Chronic Headache
- ☐ Colitis
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gallbladder problems
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Infection
- ☐ Liver Problems
- ☐ Loss of Balance
- ☐ Measles: German
- ☐ Measles: Regular
- ☐ Kidney Infection
- ☐ Mumps
- ☐ Neurological Problems
- ☐ Nongonococcal Urethritis
- ☐ Parasitic Infection
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Syphilis
- ☐ Testes Infection
- ☐ Testes Injury
- ☐ Testes Tumor
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Visual Disturbances
- ☐ Any Allergies: List _____

_____

6396 Thornberry Court • Suite 710 • Mason, OH 45040-7815 • Phone: 513.326.4300 • Fax: 513.326.4306
www.chinbaby.com

Fertility Wellness Institute
NeeOo W. Chin MD

	YES	NO
Have you ever been treated for cancer?	☐	☐
If yes, explain therapy: _____		
Within the last year, have you taken any prescription medications?	☐	☐
If yes, list all prescriptions and problems for which you were taking them: _____		
Are you taking any over-the-counter medications on a regular basis?	☐	☐
If yes, list all medications and diagnoses: _____		
Have you had a high fever (over 102°F) during the last 3-4 months?	☐	☐

Do you use or have you ever used (check all that apply):

- ☐ Alcohol – How many glasses per week do you usually drink? Wine _____ Beer _____ Cocktails _____
- ☐ Cigarettes – Number of packs per day _____
- ☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____

IV. SEXUAL HISTORY

	YES	NO
Are you circumcised?	☐	☐
When you were a child, were both testes descended into the scrotum?	☐	☐
At what age did you begin shaving regularly or start to grow a beard? _____		
How may times have you been married? _____		
Have you ever produced a child with another partner?	☐	☐
If yes, how long did it take to produce a child? _____ When was this (dates)? _____		
Have you ever tried to produce a child with another partner?	☐	☐
Do you have trouble getting an erection?	☐	☐
Maintaining an erection?	☐	☐
Do you have trouble with ejaculations?	☐	☐
If yes, ☐ Premature ejaculations ☐ Retrograde ejaculations		
Do you feel that some of your ejaculate is deposited in the vagina?	☐	☐
Do you ever have orgasms without ejaculation during masturbation?	☐	☐
Do you have any discharge from the penis?	☐	☐
How many times per week do you and your partner now have intercourse? _____		
How many times do you have intercourse around ovulation? _____		
Have you noticed a change in your sexual drive recently?	☐	☐

V. FAMILY HISTORY

	YES	NO
Is there are family history of infertility?	☐	☐
If yes, who (list all members and relationship to you): _____		
Is there are history or hormonal disorders in your family?	☐	☐
If yes, who and what type: _____		

6396 Thornberry Court • Suite 710 • Mason, OH 45040-7815 • Phone: 513.326.4300 • Fax: 513.326.4306
www.chinbaby.com

Fertility Wellness Institute
NeeOo W. Chin MD

VI. HISTORY OF INFERTILITY THERAPY

	YES	NO
Have you been treated for infertility before?	☐	☐
If yes, who was your physician: _____		
What cause of infertility was diagnosed? _____		

What drugs have you taken for infertility? Check all that appy:

- ☐ clomiphene citrate (Serophene®, Clomid®)
- ☐ hMG (Pergonal®)
- ☐ tamoxifen
- ☐ testolactone
- ☐ bromocriptine (Parlodel®)
- ☐ testosterone or Male Hormone
- ☐ hCG (Profasi®, A.P.L. ®)
- ☐ fluoxymeterone (Halotestin®)
- ☐ GnRH or LHRH (Factrel®)
- ☐ urofollitropin or FSH (Metrodin®)
- ☐ Other – Specify _____
- ☐ None

Have you ever had varicocele repair?	☐	☐
If yes, when? _____		
Have you ever had reversal or repair?	☐	☐
If yes, when? _____		
Have you and your partner ever tried artificial insemination?	☐	☐
If yes, using ☐ your sperm? ☐ donor sperm?		
Have you and your partner ever tried in vitro fertilization?	☐	☐
If yes, when and explain: _____		

Which of the following tests have you had performed? Check all that apply and the results if known:

☐ Semen Analysis	When? _____	Results: _____
☐ Chlamydia Test	When? _____	Results: _____
☐ Mycoplasma Test	When? _____	Results: _____
☐ Antibody Test	When? _____	Results: _____
☐ Hamster Egg Test	When? _____	Results: _____
☐ Chromosome Test	When? _____	Results: _____
☐ Testicular Biopsy	When? _____	Results: _____
☐ X-ray or Ultrasound of Testes	When? _____	Results: _____
☐ Hormonal Test (FSH, LH, prolactin, testosterone)	When? _____	Results: _____
☐ Thyroid Tests	When? _____	Results: _____
☐ Other – Specify _____	When? _____	Results: _____

Is your partner seeing a doctor for evaluation of infertility?	☐	☐
If yes, specify physician name and location: _____		
Does the doctor feel that your partner has an infertility problem?	☐	☐
If yes, what is the diagnosis and how is she being treated? _____		
Has she ever had children with another man?	☐	☐
If yes, when? _____		

6396 Thornberry Court • Suite 710 • Mason, OH 45040-7815 • Phone: 513.326.4300 • Fax: 513.326.4306
www.chinbaby.com