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ISIS REGIONAL FERTILITY CENTRE

Male Partner History Form:

Name:

Ethnic Origin:

Age:

Occupation:

1. Any children from a previous relationship? Yes or No
 - a. Pregnancy outcome? (eg. Healthy child?)
2. Any history of infections or injuries of the penis or prostate? Yes or No
3. Any history of gonorrhea, chlamydia or genital warts? Yes or No
4. Undescended testicles as a baby? Yes or No
 - a. Was this corrected with surgery? Yes or No
 - b. At what age did this surgery occur?
5. Have you had surgery for any of the following:
 - a. Hernia repair Yes or No
 - b. Varicocele Yes or No
 - c. Previous vasectomy? Yes or No
 - i. What year did this occur?
 - d. Previous reversal of vasectomy?
 - i. What year did this occur?
 - e. Any other type of surgery:
6. Do you have any history of medical problems? Yes or No
 - a. What ones?
7. What prescription medications do you take regularly?
8. Do you use any over the counter medications or complementary and alternative medications?
9. Do you have any allergies? Yes or No
 - a. To medications?
 - b. To latex?

10. Do you smoke? Yes or No
a. How much?

11. How many alcohol drinks per week?

12. Are your exposed to any chemicals in your home and workplace? Yes or No
a. What kind of exposure?

13: Are you exposed to excessive heat to the testicles (hot-tub, work-related):

14: Family History:

	Yes	No	Who	Provide Details
Neural tube defects				
Mentally challenged				
Recurrent pregnancy loss				
Genetic problems (chromosomes)				
Any others – what are they?				