

# CNY Fertility Center

**Please complete to the best of your knowledge, print clearly in ink**

## CONFIDENTIAL HISTORY (Male)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: S M D Sep Widow

Occupation: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Past Medical History:

List Allergies to any medications: NONE KNOWN

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

Current medications: NONE

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

Surgeries or Hospitalizations: NONE

1) \_\_\_\_\_ 3) \_\_\_\_\_

2) \_\_\_\_\_ 4) \_\_\_\_\_

## Semen Analysis:

Date: \_\_\_\_\_ Place: \_\_\_\_\_ Results: \_\_\_\_\_

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<b>Medical History: (Have you ever had?)</b>	NO	YES	(Comments)
Hypertension: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung disease / Asthma: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver disease or Hepatitis: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease or Urinary tract infections: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure or Neurological disorders: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood transfusions: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease or Strokes: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fevers: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight loss or gain: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach problems: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety or Depression: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Tendencies: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>Social History:</b>	NO	YES	
<u>Tobacco use:</u>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, number of packs and years of use: _____
<u>Alcohol use:</u>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, glasses per day / week: _____ / _____
<u>Drugs:</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Intravenous drugs:</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Multiple sexual partners:</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Do you exercise regularly:</u>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, How often / How much: _____
<u>Marital Status:</u>	Single <input type="checkbox"/> Married <input type="checkbox"/> _____		
<u>How long with current partner:</u>	_____		

**Family History: (Age and Health)**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

## *CNY Fertility Center*

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**Have any of your blood relatives ever had?**

	<b>NO</b>	<b>YES</b>	<b>(Comments)</b>
<b>Diabetes:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Heart disease:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Birth defects or Genetic disorders:</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Tuberculosis:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Breast disease:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Cancer:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Stroke:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Kidney disease:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Seizures or Neurological disorders:</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Hepatitis or Liver disease:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Blood clots or bleeding problems:</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Problems with Anesthesia:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Other:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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**Other Information:**