Male General Information Form

Date: ______________________

Name: ___________________________ Age: ______ DOB: ____________
Last: ___________________ First: ____________

Name of spouse: ___________________________ Age: ______ DOB: ____________
Last: ___________________ First: ____________

Referring physician: ___________________________ Primary care physician: ___________________________

Number of years married: _______ Number of prior marriages: _______
Age(s) of children, if any: _______ Number of pregnancies with previous spouse: _______

Past Medical History

Please circle the appropriate answer:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had mumps</td>
<td></td>
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<tr>
<td>Heart problems</td>
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<tr>
<td>Hormonal problems (thyroid, diabetes, etc.)</td>
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<td>Other medical problems</td>
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<td>Lung problems (asthma, etc.)</td>
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<td>Muscle or joint problems</td>
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<td>Neurological problems</td>
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<td>Stomach problems</td>
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<tr>
<td>Other surgery</td>
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<tr>
<td>Current medications</td>
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<tr>
<td>ALLERGY to medications</td>
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</tbody>
</table>

Male History

Please circle the appropriate answer:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Abnormal sexual development</td>
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<tr>
<td>Bladder or prostate surgery</td>
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<td>Ejaculation problems</td>
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<td>Epididymitis</td>
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<td>Fever within the last three months</td>
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<td>Had hernia repair</td>
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<tr>
<td>Injury to the testicles</td>
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<td>Problem achieving erections</td>
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<tr>
<td>Puberty was early (&lt;12 years)</td>
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<tr>
<td>Puberty was late</td>
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<tr>
<td>Sex drive problems</td>
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<tr>
<td>Sexually transmitted disease</td>
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<tr>
<td>Undescended testicles</td>
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<tr>
<td>Urinary tract infection</td>
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<tr>
<td>Varicocele diagnosis</td>
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<tr>
<td>Vasectomy</td>
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<td>Vasectomy reversal</td>
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<td>Other family member with fertility problem</td>
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</tbody>
</table>
Social History

Please circle the appropriate answer:

- Drink alcohol (# drinks/week) __________ yes no
- Exposure to chemicals yes no
- Radiation exposure (not routine x-rays) yes no
- Recreational drugs yes no
- Regular exposure to heat (sauna, baths, jacuzzi) yes no
- Smoker (# packs/day) yes no

Family History

Has anybody in your family had any of the following:

- Blindness yes no
- Birth defects yes no
- Chromosome problem yes no
- Cystic fibrosis yes no
- Deafness yes no
- Diabetes yes no
- Down syndrome yes no
- Heart attack (<50 years) yes no
- Hemophilia yes no
- High blood pressure yes no
- Mental retardation yes no
- Muscular dystrophy yes no
- Polycystic kidneys yes no
- Psychiatric disease yes no
- Sickle-cell anemia yes no
- Spina bifida yes no
- Tay-Sachs disease yes no
- Thyroid disease yes no
- Other genetic disorders yes no

Ancestral Background

There are certain ancestral backgrounds that have an increase frequency of some genetic disease. Please indicate if either your mother or father are of any of the following backgrounds:

- African
- Asian
- Caribbean
- French Canadian
- Indian
- Jewish
- Latin American
- Mediterranean
- Native American
- None of the above

Other Possible Concerns

Please circle the appropriate answer:

- Biopsy of testicles yes no
- Cancer yes no
- Colitis yes no
- DES exposure in womb yes no
- Diabetes yes no
- Genital herpes yes no
- Genital warts/condyloma yes no
- High blood pressure yes no
- Mumps with injury to testicles yes no
- Penile discharge or pain yes no
- Physical abnormality yes no
- Prostatitis yes no
- Psychiatric treatment yes no
- Seizures yes no
- Strenuous exercise yes no
- Tight underwear yes no
- Varicocele yes no
- Varicocele surgery yes no
- Urethritis/epididymitis yes no

Comments

__________________________________________________________________________________________

__________________________________________________________________________________________