WOMEN'S HEALTH CLINIC
Male History Form

FOR OFFICE USE ONLY

IMPORTANT:
Please complete prior to your followup visit.

This form was developed by the staff at NMPC Women's Health Department to assist physicians and patients in obtaining a complete infertility and environmental history.

PART I: CONTACT INFORMATION

Age _____

Legal First Name _____ **Middle Initial** ____ **Last Name** _____

Date of Birth (MM/DD/YY) _____/_____/_____ Occupation _____

Military Branch: _____

Age _____

Spouse/Female Partner's First Name _____ **Middle Initial** ___ **Last Name** _____

☐Not Applicable

Date of Birth (MM/DD/YY) _____/_____/_____

MEDICAL HISTORY AND INFORMATION

Complete to the best of your ability

• Date of your semen analysis: _____
• Have you previously fathered a pregnancy? ☐Yes: How many times?_____
☐ Liveborn child ☐ Miscarriage ☐ Elective abortion ☐ I don't know
☐No
• When did you & your partner **stop** trying to **prevent** pregnancy? ☐<1 yr ago ☐ >1yr ago
• Do you have difficulty with erections? ☐Yes ☐No
• • Have you had any of the following sexually transmitted diseases or pelvic infections? ☐Yes (check all that apply) ☐No
☐ Chlamydia - date_____ ☐ Gonorrhea - date_____ ☐ Herpes - date_____ Genital warts/HPV - date_____
• Have you had a history of undescended testicles? ☐Yes - One side___ Both___ ☐No
• Have you had prior injury to your testicles requiring hospitalization? ☐Yes ☐No

• Have you been diagnosed with any of the following diseases?

☐ Diabetes Mellitus - Yes___ No___
☐ Multiple Sclerosis - Yes___ No___
☐ Prostatic infections - Yes___ No___
☐ High Blood Pressure - Yes___ No___ If yes, any medications?_____
☐ Cancer - Yes___ No___
☐ Other neurologic problems - Yes___ No___
☐ Urinary infections - Yes___ No___

• Have you had any fever in the last 3 months? ☐Yes ☐No
• Have you had a vasectomy? ☐Yes (date_____) ☐No
If yes, have you had a vasectomy reversal? ☐Yes (date_____) ☐No
• Have you had surgery for varicocele repair? ☐Yes ☐No
• Have you had hernia surgery? ☐Yes ☐No
• Did you undergo any bladder or penis surgery as a child? ☐Yes ☐No
• Have you had chemotherapy for cancer? ☐Yes ☐No

List your current medications:_____

List any current medical problem(s):_____

• Do you use herbal medicines/vitamins or health food store supplements? ☐Yes (describe_____) ☐No

DEPLOYMENT HISTORY

• Were you deployed at any time within 6 months prior to your semen analysis? ☐Yes ☐No

If Yes:

- How long were you deployed? _____
- In what country did you spend most of your deployment? _____
- Where did you spend most of your time at work? (if on ship, which ship/deck?) _____
- How would you describe your job while deployed? _____
- Where you exposed to burn pits while deployed? ☐Yes ☐No
  If yes, how many days per week were you exposed to burn pits? _____ ☐Unknown
- How do you perceive the surrounding air quality while you were deployed? ☐Good ☐Fair ☐Poor

EXPOSURE HISTORY

• Do you smoke cigarettes? ☐Yes ☐No
If yes, How many/day?_____ How many years?_____ ☐Quit - when?_____

Within 6 months prior to your semen analysis:

• Personal use of cigarettes/cigars? ☐Yes ☐No
• Second hand cigarette/cigar use? ☐Yes ☐No
• Industrial cleaning supplies? ☐Yes ☐No
If Yes, how often?: ☐Daily ☐ Few times/week ☐Weekly ☐Rarely
• Paint fumes? ☐Yes ☐No
If Yes, how often?: ☐Daily ☐ Few times/week ☐Weekly ☐Rarely
• Testosterone/ hCG injections? ☐Yes ☐No
If Yes, how often?: ☐Daily ☐ Few times/week ☐Weekly ☐Rarely
• Are you aware of any radiation/toxic materials exposure? ☐Yes ☐No

- If Yes, how often?: ☐Daily ☐ Few times/week ☐Weekly ☐Rarely
- If yes, does your job require you to wear a dosimetry badge? ☐Yes ☐No
- Have you ever exceeded the maximum allowed radiation dose?
  ☐Yes, Once ☐Yes, multiple times ☐No

Family History

Living	Cause of Death/Age at Death	
• Mother	☐Yes - age___	☐No _____
• Father	☐Yes - age___	☐No _____
• Brother(s)	☐Yes - age___	☐No _____
	☐Yes - age___	☐No _____
• Sister(s)	☐Yes - age___	☐No _____
	☐Yes - age___	☐No _____
• Maternal Grandmother	☐Yes - age___	☐No _____
• Maternal Grandfather	☐Yes - age___	☐No _____
• Paternal Grandmother	☐Yes - age___	☐No _____
• Paternal Grandfather	☐Yes - age___	☐No _____

Disorders in Your Family

Relationship to You		
• Cystic Fibrosis	☐Yes _____	☐No ☐Don't Know
• Tay-Sachs disease	☐Yes _____	☐No ☐Don't Know
• Canavan disease	☐Yes _____	☐No ☐Don't Know
• Bloom syndrome	☐Yes _____	☐No ☐Don't Know
• Gaucher disease	☐Yes _____	☐No ☐Don't Know
• Niemann-Pick disease	☐Yes _____	☐No ☐Don't Know
• Fanconi Anemia	☐Yes _____	☐No ☐Don't Know
• Familial Dysautonia	☐Yes _____	☐No ☐Don't Know
• Muscular Dystrophy	☐Yes _____	☐No ☐Don't Know
• Neurologic (brain/spine)	☐Yes _____	☐No ☐Don't Know
• Neural Tube Defects	☐Yes _____	☐No ☐Don't Know
• Bone/Skeletal Defects	☐Yes _____	☐No ☐Don't Know
• Dwarfism	☐Yes _____	☐No ☐Don't Know
• Developmental delay	☐Yes _____	☐No ☐Don't Know
• Learning problems	☐Yes _____	☐No ☐Don't Know
• Polycystic kidney disease	☐Yes _____	☐No ☐Don't Know
• Heart defect from birth	☐Yes _____	☐No ☐Don't Know
• Down syndrome	☐Yes _____	☐No ☐Don't Know
• Other chromosome defects	☐Yes _____	☐No ☐Don't Know
• Marfan syndrome	☐Yes _____	☐No ☐Don't Know
• Hemophilia	☐Yes _____	☐No ☐Don't Know
• Sickle Cell Anemia	☐Yes _____	☐No ☐Don't Know
• Thalassemia	☐Yes _____	☐No ☐Don't Know
• Galactosemia	☐Yes _____	☐No ☐Don't Know
• Deafness/Blindness	☐Yes _____	☐No ☐Don't Know
• Color Blindness	☐Yes _____	☐No ☐Don't Know
• Hemochromatosis	☐Yes _____	☐No ☐Don't Know
• High blood pressure	☐Yes _____	☐No ☐Don't Know
• Glaucoma	☐Yes _____	☐No ☐Don't Know
• High cholesterol	☐Yes _____	☐No ☐Don't Know
• Gallstones	☐Yes _____	☐No ☐Don't Know
• Hepatitis	☐Yes _____	☐No ☐Don't Know

• ☐None of the above ☐☐Other (Specify _____

What is your Ancestry?

☐African-American
☐Native A m e r i c a n
☐Ashkenazi Jewish
☐Asian-Chinese
☐Asian-Japanese
☐Asian-Korean
☐Asian-Indian
☐Asian-Filipino
☐Asian-Vietnamese
☐Asian-Other: _____
☐Caucasian-Northern European
☐Caucasian-Russian
☐Caucasian-Southern European
☐Hispanic – Mexican
☐Hispanic – South America Country of Origin: _____
☐Hispanic – Central American Country of Origin: _____
☐Hispanic – Spain
☐Middle Eastern-Country of Origin:_____
☐African-Country of Origin: _____
☐Other (specify_____)

SPOUSE/MALE PARTNER'S SIGNATURE_____ **DATE**_____