

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

DOB: \_\_\_/\_\_\_/\_\_\_



# Alabama Center for Reproductive Medicine

## Male New Patient Medical History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Initial Apt Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Height: \_\_\_\_\_

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

Primary Contact #: \_\_\_\_\_ Secondary Contact #: \_\_\_\_\_

Email: \_\_\_\_\_ Race: \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_

Pharmacy City, State: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Partner name (if applicable): \_\_\_\_\_ Partner occupation: \_\_\_\_\_

Partner phone #: \_\_\_\_\_ Partner DOB: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

### History

Have you had a previous vasectomy? \_\_\_\_\_ Have you had it reversed? \_\_\_\_\_

History of infertility in a prior relationship? \_\_\_\_\_

Have you seen a urologist for infertility evaluation? \_\_\_\_\_ If yes, who? \_\_\_\_\_

When? \_\_\_\_\_

Have you had a semen analysis? \_\_\_\_\_ When? \_\_\_\_\_

Result: \_\_\_\_\_

Number of pregnancies with current partner: \_\_\_\_\_

Number of pregnancies with prior relationship(s): \_\_\_\_\_

List any sexually transmitted disease you have had (such as syphilis, gonorrhea, herpes, genital warts, ect): \_\_\_\_\_  
\_\_\_\_\_

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Alcohol consumption: Current \_\_\_\_\_ beverages/week Past \_\_\_\_\_ beverages/week

Have you ever smoked a cigarette? \_\_\_\_\_ If yes, when did you quit? \_\_\_\_\_

Cigarette use: Current \_\_\_\_\_ packs/day Past \_\_\_\_\_ packs/day

How many years have you smoked? \_\_\_\_\_

Do you dip or chew tobacco? \_\_\_\_\_ If you vape, how many times per day? \_\_\_\_\_

Recreational/illegal drug use (please specify): Current: \_\_\_\_\_

Past: \_\_\_\_\_

How many caffeinated beverages do you have per day? \_\_\_\_\_

Have you ever undergone chemotherapy or radiation? (If yes, please explain)

\_\_\_\_\_

Are you currently taking testosterone in any form? \_\_\_\_\_ Have you ever? \_\_\_\_\_

How long? \_\_\_\_\_

Do you have any medication allergies? \_\_\_\_\_

#### Current Medications

Medication	Frequency	Indication
_____	_____	_____
_____	_____	_____
_____	_____	_____

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### Review of Systems

#### General

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble Sleeping

#### Skin

- Rashes
- Lumps
- Itching
- Dryness
- Hair and nail changes

#### Ears

- Decreased Hearing
- Ringing in ears
- Earache
- Drainage

#### Eyes

- Glasses or contacts
- Pain
- Redness
- Blurry or double vision
- Flashing lights
- Specks
- Cataracts
- Glaucoma
- Last eye exam \_\_\_\_\_

#### Neck

- Lumps
- Swollen glands
- Stiffness
- Pain

#### Nose

- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain

#### Throat

- Dry mouth
- Bleeding gums
- Dentures
- Sore throat
- Dry mouth
- Hoarseness
- Thrush
- Non-healing sores
- Last dental exam \_\_\_\_\_

#### Respiratory

- Sputum
- Wheezing
- Painful breathing
- Coughing up blood
- Shortness of breath
- Cough

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### Review of Systems Cont.

#### Urinary

- Increased frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinent
- Change in urinary strength

#### Vascular

- Calf pain with walking (claudication)
- Leg cramping

#### Neurological

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremors

#### Cardiovascular

- Difficulty breathing lying down
- Chest pain/discomfort
- Tightness
- Palpitations
- Swelling (adema)

#### Genital

- Pain with sex
- Hernia
- Sores
- Penile discharge
- Itching or rash
- STDs
- Erectile dysfunction
- Masses or pain

#### Hematologic

- Ease of bruising
- Ease of bleeding

#### Psychiatric

- Nervousness
- Depression
- Memory loss
- Stress

#### Musculoskeletal

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

#### Endocrine

- Head or cold intolerance
- Sweating
- Excessive thirst (polydipsia)

#### Gastrointestinal

- Swallowing difficulties
- Change in appetite
- Nausea
- Constipation
- Rectal bleeding
- Change in bowel habits
- Heartburn
- Yellow eyes/skin
- Diarrhea