

MALE PATIENT HISTORY

Date _____

Name _____

Weight _____ Height _____ Blood Type (if known) _____

Are you, or have you ever been exposed to any of the following during employment or military service?

If so, please explain,

Heat _____ Toxic fumes _____

Chemicals _____ Nuclear radiation _____

Other _____

What medications do you regularly take? (Prescription and/or over the counter drugs)

Do you frequently take saunas or steam baths? _____

Do you or have you ever, used:

Alcohol? How many drinks per week? _____

Cigarettes? How many packs per day? _____

Illicit or recreational drugs? _____

Have you ever been treated for infertility in the past? _____

If yes, please review diagnostic studies and treatments with our physician during your appointment.

Please list all types and dates of surgeries you have undergone: _____

Allergies? (circle) yes or no If yes, please list: _____

Have you ever been treated for cancer? _____

Family history of blood clotting disorders? _____

If yes, please explain? _____

Do you, or have you ever, had (circle all that apply):

Anemia

Appendicitis

Arthritis

Bleeding disorder

Blood transfusion

Chlamydia

Chronic bronchitis

Chronic headaches

Colitis

Cystic Fibrosis

Diabetes

Dizziness

Epilepsy

Gallbladder problems

Gonorrhea

Heart disease

Hepatitis

Herpes

High blood pressure

Kidney infection

Liver problems

Loss of balance

Measles: German

Measles: Regular

Mumps

Mumps w/testes involved

Neurological problems

Nongonococcal urethritis

Parasitic infection

Pneumonia

Prostatitis

Rheumatic fever

Scarlet fever

Seizures

Syphilis

Testes infection

Testes injury

Testes tumor

Thyroid problems

Tuberculosis

Visual disturbances

Cancer (specify) _____

Countries of origin: Mother's family: _____ Father's family: _____

Ethnic background (Circle) : African American Asian Asian-Indian Caucasian Hispanic

Jewish American-Indian Mediterranean Middle Eastern
Other: _____

Ethnic Group

<u>(Check all that apply)</u>	<u>Have you ever been tested for:</u>	<u>Yes</u>	<u>No</u>	<u>Date</u>	<u>Result</u>
African, African/American	Sickle cell trait	_____	_____	_____	_____
Chinese, Southeast Asian, Mediterranean (Greek or Italian) or Hispanic	Thalassemia	_____	_____	_____	_____
Caucasian, Jewish	Cystic Fibrosis	_____	_____	_____	_____
Jewish	Bloom Syndrome,	_____	_____	_____	_____
	Canavan Familial Dysautonomia (FD),	_____	_____	_____	_____
	Fanconi Anemia (type C),	_____	_____	_____	_____
	Gaucher Disease (Type I),	_____	_____	_____	_____
	Glycogen Storage (Type 1a),	_____	_____	_____	_____
	Maple Syrup Urine Disease,	_____	_____	_____	_____
	Mucopolidosis, (Type IV ML IV),	_____	_____	_____	_____
	Niemann - Pick Type A,	_____	_____	_____	_____
	Tay Sachs	_____	_____	_____	_____

Other inherited disorders? _____

Would you like to be tested for the test recommended for your specific ethnic group? (Circle) **Yes No**

Are you related to your spouse (consanguinity)? _____

Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed (Circle)? **Yes No**