Orchid
chinese medicine & acupuncture

Male Reproductive History

Please take the time to fill out this questionnaire carefully. The information you provide will assist in making appropriate decisions about your treatment. All information is treated as confidential unless you grant permission to release it. If you have any questions, please ask. PLEASE PRINT AND COMPLETE.

Patient Name: _____ Age: _____

Date: _____ Name of spouse/partner: _____

Name of Fertility Specialist: _____

FERTILITY HISTORY

How long have you been trying to conceive with your partner: _____

Have you had any diagnosis relating to fertility: ___Yes ___No

Describe: _____

Have you had any fertility treatments: ___Yes ___No

When: _____

Type: _____

Physician: _____

Have you fathered any children: ___Yes ___No When: _____

With your current partner: ___Yes ___No

Have you had a Semen Analysis: ___Yes ___No

Date	Count	Morphology	Motility	Volume
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you been examined by a urologist: ___Yes ___No

Results: _____

Have you had any microsurgery, or other operations: ___Yes ___No

For what condition: _____

Result: _____

Have you had any hormonal blood-work evaluations: ___Yes ___No

Result: _____

Have you had any other diagnostic procedures: ___Yes ___No

Type: _____

HEALTH HISTORY

At what age did you begin puberty: _____
Have you ever suffered a trauma to your reproductive organs: ___Yes ___No
When: _____ Describe: _____
Have you ever had a kidney infection: ___Yes ___No When: _____
Have you ever had a urinary tract or bladder infection: ___Yes ___No When: _____
Have you ever had inflammation of the prostate: ___Yes ___No When: _____
Have you had any testicular masses or nodules: ___Yes ___No What: _____
Have you ever had a hernia: ___Yes ___No What: _____
Do you have a history of undescended testes: ___Yes ___No
When did it resolve: _____
Have you had the mumps as a child: ___Yes ___No, When: _____
Was your mother exposed to DES while pregnant with you: ___Yes ___No
Have you been treated for any sexually transmitted disease: ___Yes ___No
When: _____ Describe: _____
Have you had any recent illnesses, colds or flus: ___Yes ___No
When: _____ Describe: _____
Have you been diagnosed with any other medical conditions: ___Yes ___No
When: _____ Describe: _____
Have you been diagnosed with varicocele: ___Yes ___No
Have you had any procedures including varicocele repair, vasectomy, vasectomy reversal, SCSA/ASA: ___Yes ___No
When: _____ Describe: _____

LIFESTYLE

How is your sexual energy: ___Good ___ Fair ___ Low
Do you use condoms with spermicidal agents: ___Yes ___No

Do you have a very stressful job: ___Yes ___No
Are you frequently exposed to environmental toxins or pollutants: ___Yes ___No
Describe: _____
Does your job involve sitting at a desk all day: ___Yes ___No
Do you have a stressful home environment: ___Yes ___No

Do you use recreational drugs: ___Yes ___No Do you smoke cigarettes: ___Yes ___No
Do you drink alcohol: ___Yes ___No How often: _____

Do you have an exercise routine: ___Yes ___No Describe: _____

What do you do for relaxation: _____

Do you have difficulty sleeping: ___Yes ___No Describe: _____

Are you overweight: ___Yes ___No How many pounds: _____
Are you underweight: ___Yes ___No How many pounds: _____
Do you struggle to maintain a consistent weight: ___Yes ___No How so: _____

MEDICATIONS

Have you recently taken antibiotics: ___Yes ___No

What/When: _____

Have you ever taken steroids: ___Yes ___No

What/When: _____

Do you take any over the counter medications: ___Yes ___No

Type: _____

Do you take any prescription medications: ___Yes ___No

Type: _____

_____

Do you use any anti-fungal creams or applications: ___Yes ___No

Do you take any nutritional supplements or herbal products: ___Yes ___No

Type: _____

_____

SYMPTOMS

Do you ever experience impotence: ___Yes ___No

Do you ever have painful erections: ___Yes ___No

Do you have difficulty sustaining an erection: ___Yes ___No

Do you ever experience nocturnal emissions: ___Yes ___No

Do you ever experience premature ejaculation: ___Yes ___No

Do you ever experience difficulty or inability to ejaculate: ___Yes ___No

Do you ever experience a loss of libido: ___Yes ___No

Do you ever feel your libido is too high: ___Yes ___No

Do you experience coldness in your scrotum: ___Yes ___No

Do you experience swelling in your scrotum: ___Yes ___No

Do you experience any pain or discomfort in your scrotum, or testes: ___Yes ___No

Do you ever have a heavy or bearing down sensation in your testicles: q___Yes ___No

Do you notice any abnormal discharge from your penis: ___Yes ___No

Do you experience genital itching: ___Yes ___No

Do you have any genital rashes or sores: ___Yes ___No

Do you have frequent urination: ___Yes ___No

Do you have interrupted urine flow: ___Yes ___No

Do you have scanty urine: ___Yes ___No

Do you have copious urine: ___Yes ___No

Is your urine generally light yellow: ___Yes ___No

Is your urine generally dark yellow: ___Yes ___No

Does your urine have a strong odor: ___Yes ___No

Does your urine feel hot: ___Yes ___No

Do you experience pain with urination: ___Yes ___No

Do you ever have slight incontinence or dribbling of urine: ___Yes ___No

OTHER COMMENTS

_____

_____

_____

_____

_____