**Fertility History – Male**

| Name: | Name of Spouse: |
|---|---|

How long have you and your partner been trying to conceive?_____

| | | |
|---|---|---|
| How would you define your sexual energy? | ☐ Below Normal | ☐ Normal |
| Have you had a recent physical exam? | ☐ Yes | ☐ No |
| Do you or did you have an undescended testicle? | ☐ Yes | ☐ No |
| Have you ever been diagnosed with a varicocele? | ☐ Yes | ☐ No |
| Have you ever had any urologic surgeries? | ☐ Yes | ☐ No |
| Have you experienced erectile dysfunction? | ☐ Yes | ☐ No |
| Have you experienced difficulty ejaculating? | ☐ Yes | ☐ No |
| Have you had exposure to any known environmental toxins or hormones? | ☐ Yes | ☐ No |
| Have you experienced any penile discharge? | ☐ Yes | ☐ No |
| Do you regularly experience nocturnal emissions? | ☐ Yes | ☐ No |
| Do you have high cholesterol? | ☐ Yes | ☐ No |
| Have you experienced a high fever in the last six months? | ☐ Yes | ☐ No |
| Do you currently have any prostate conditions? | ☐ Yes | ☐ No |
| Do you have or have you ever had urinary infections or STD's? | ☐ Yes | ☐ No |
| Have you ever taken testosterone supplements/drugs? | ☐ Yes | ☐ No |
| Have you recently had your testosterone levels checked? | ☐ Yes | ☐ No |
| Have you been diagnosed with small or soft testes? | ☐ Yes | ☐ No |
| Have you been checked for a blockage of your reproductive tracts? | ☐ Yes | ☐ No |

| | | | |
|---|---|---|---|
| Have you had a fertility work-up? Yes____ No____ | | | |
| If yes, what was your sperm count? | ☐ Below Normal | ☐ Normal | Number:_____ |
| What was the sperm motility? | ☐ Below Normal | ☐ Normal | Notes:_____ |
| What was the sperm morphology? | ☐ Abnormal | ☐ Normal | Notes:_____ |

**Additional Comments:**

Please print and complete forms before your initial appointment. Thank you.