Male Fertility Intake

NAME ___________________________________ AGE___ DATE ___________

Partner's name __________________________ AGE___

Have you been given a diagnosis related to fertility? If so, what is it?____

How long have you and your partner been trying to get pregnant?_____________________________

Have you tried any fertility treatments? If yes please answer the following:

Treatment type	Result	Dr. or clinic name	Date

UROGENTIAL HISTORY

Do you have a history of any varicocele? Y / N

Have you ever had undescended testes? Y / N

Have you had any urogenital surgeries? Y / N If yes, explain_______________________

Have you ever had any trouble maintaining an erection? Y / N

If so did the problem exist with self stimulation? Y / N

Have you ever experienced premature ejaculation? Y / N

Do you experience a morning erection? Y / N

Do you experience nocturnal emissions regularly? Y / N

Have you ever experienced any issues with low libido? Y / N

Have you ever experienced abnormal discharge from your penis? Y / N

Have you been exposed to any environmental toxins? Y / N

LAB TESTING

Have you had a sperm analysis? Y / N If yes what were the results?

Count results ____

Motility results____

Morphology results____

DNA sperm fragmentation results_____________________________________

FERTILTY HISTORY

Have you had children previously? Y / N

How long did it take to conceive?_____________

Do you cycle regularly? Y / N Do you take a hot tub/ sauna/ hot bath regularly? Y / N

Any other issues you'd like us to know about?

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