University of Washington Medical Center
University Reproductive Care

MALE FERTILITY HISTORY FORM

Please complete this form and bring it with you to your scheduled appointment.

CONTACT INFORMATION:

First name: _____ Middle initial: ____ Last name:_____

Preferred name: _____ Self-declared gender: _____

Preferred pronoun (he/him, she/her etc.) _____

Date of Birth: ____/____/____ Age: _____ Occupation:_____

Home Street Address:_____

City: _____ State: _____ Zip/Postal Code: _____

Indicate which number to call or leave messages

□ Home Phone: (___) _____ □ Cell Phone: (___)_____ □ Work Phone:(___)_____

Are you married? □ Yes □ No □ Divorced □ Other _____

Spouse/Partner: □ Not Applicable

First name: _____ Middle Initial: ____ Last Name:_____

Date of Birth: ____/____/____ Age: _____ Occupation:_____

Home Street Address:_____

City: _____ State: _____ Zip/Postal Code: _____

Indicate which number to call or leave messages

□ Home Phone: (___) _____ □ Cell Phone: (___)_____ □ Work Phone:(___)_____

Who referred you?

□ Physician Name: _____Clinic: _____

PLACE PATIENT LABEL HERE

Phone: (___)_____Address: _____

□ Former Patient/Friend: _____

□ Website/Advertisement: _____ □ Insurance Carrier: _____

Who is your primary care provider (if different than above)?

Name: _____Clinic: _____ Phone: (___) _____

Address: _____

MALE MEDICAL HISTORY AND INFORMATION:

□ Have you been evaluated by a urologist? □ Yes □ **No**
□ Have you previously fathered a pregnancy?
□ Yes: How many times?_____ □ **No**
□ Have you had a semen analysis? □ Yes □ **No**
If yes, your result:_____
□ Do you have difficulty with erections? □ Yes □ **No**
□ Do you have retrograde ejaculation of sperm into bladder? □ Yes □ **No**

Have you been treated for or diagnosed with one of the following sexually transmitted infections?
□ **No** □ Yes (Please check all that apply and provide the date of diagnosis)
□ Chlamydia _____ □ Gonorrhea _____ □ Herpes _____ □ Hepatitis B _____
□ Genital warts (HPV) _____ □ Syphilis _____ □ HIV/AIDS _____

□ Do you have a history of undescended testicles? □ Yes □ **No**
□ Do you have scrotal or testicular pain? □ Yes □ **No**
□ Did you have the mumps after puberty? □ Yes □ **No**
□ Have you had prior injury to your testicles requiring hospitalization? □ Yes □ **No**

□ Have you been diagnosed with any of the following diseases?

Diabetes Mellitus □ Yes □ **No**	Cancer □ Yes □ **No**
Multiple Sclerosis □ Yes □ **No**	Other neurologic problems □ Yes □ **No**
Prostate infection □ Yes □ **No**	Urinary infections □ Yes □ **No**
High Blood Pressure □ Yes □ **No**	

□ Have you had any fever in the last 3 months? □ Yes □ **No**
□ Have you had a vasectomy? □ Yes (date____/____) □ **No**
If yes, have you had a vasectomy reversal? □ Yes (date____/____) □ No
□ Have you had surgery for varicocele repair? □ Yes □ **No**
□ Have you had hernia surgery? □ Yes □ **No**
□ Did you undergo any bladder or penis surgery as a child? □ Yes □ **No**

□ Are you exposed to prolonged heat in the workplace? □ Yes □ **No**
□ Are you exposed to any radiation or harmful chemicals in the workplace? □ Yes □ **No**
□ Have you had chemotherapy for cancer? □ Yes □ **No**

Are you allergic to any medications or foods? □ **No** □ Yes (list allergies and describe reactions)

Drug or food	Reaction

List all medications, including over-the-counter medicines, herbal remedies, and vitamins

Medication	Dose	Why are you taking this medication?

Do you have any medical problem(s)? □ **No** □ Yes (please list type, dates and treatments)

Medical problem	Diagnosis date	Treatments

Social History:
Number of caffeinated beverages (coffee, tea, soda) per day? _____
Do you smoke cigarettes? □ **No** □ Quit/when_____ □ Yes
Number of years_____ Number of cigarettes per day _____
Do you drink alcohol? □ **No** □ Yes
Number of drinks per week: Beer ____ Wine ____ Liquor _____
Do you use recreational drugs (i.e. marijuana)? □ **No**
□ Yes (describe) _____
□ Are you aware of any radiation/toxic material exposure? □ Yes □ **No**
□ Do you use hot tubs regularly? □ Yes □ **No**
□ Have any of your immediate family members had difficulty conceiving a child? □ Yes □ **No**
If yes, please describe_____

ZIKA and West Nile exposure

Have you or your partner traveled to a Zika Virus Zone? ☐ **No** ☐ Yes
Have you or your partner traveled to a West Nile Zone? ☐ **No** ☐ Yes
Do you or your partner plan to travel to a Zika Virus or West Nile zone? ☐ **No** ☐ Yes

Have you or your partner experienced any of the following in the last 6 months?
Fever: ☐ **No** ☐ Yes Rash: ☐ **No** ☐ Yes Joint pain or body aches: ☐ **No** ☐ Yes
Conjunctivitis: ☐ **No** ☐ Yes Headache: ☐ **No** ☐ Yes

Disorders in Your Family		**Relationship to you**		
Birth Defects	☐ Yes	_____	☐ No	☐ Don't Know
Cystic Fibrosis	☐ Yes	_____	☐ No	☐ Don't Know
Tay-Sachs Disease	☐ Yes	_____	☐ No	☐ Don't Know
Canavan Disease	☐ Yes	_____	☐ No	☐ Don't Know
Bloom Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Gaucher Disease	☐ Yes	_____	☐ No	☐ Don't Know
Niemann-Pick Disease	☐ Yes	_____	☐ No	☐ Don't Know
Fanconi Anemia	☐ Yes	_____	☐ No	☐ Don't Know
Familial Dysautonia	☐ Yes	_____	☐ No	☐ Don't Know
Muscular Dystrophy	☐ Yes	_____	☐ No	☐ Don't Know
Neurologic (brain/spine)	☐ Yes	_____	☐ No	☐ Don't Know
Neural Tube Defects	☐ Yes	_____	☐ No	☐ Don't Know
Bone/Skeletal Defects	☐ Yes	_____	☐ No	☐ Don't Know
Dwarfism	☐ Yes	_____	☐ No	☐ Don't Know
Developmental Delays	☐ Yes	_____	☐ No	☐ Don't Know
Learning Problems	☐ Yes	_____	☐ No	☐ Don't Know
Polycystic Kidneys	☐ Yes	_____	☐ No	☐ Don't Know
Heart defect from birth	☐ Yes	_____	☐ No	☐ Don't Know
Down Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Other Chromosome defects	☐ Yes	_____	☐ No	☐ Don't Know
Marfan Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Hemophilia	☐ Yes	_____	☐ No	☐ Don't Know
Sickle Cell Anemia	☐ Yes	_____	☐ No	☐ Don't Know
Thalassemia	☐ Yes	_____	☐ No	☐ Don't Know
Galactosemia	☐ Yes	_____	☐ No	☐ Don't Know
Deafness/Blindness	☐ Yes	_____	☐ No	☐ Don't Know
Color Blindness	☐ Yes	_____	☐ No	☐ Don't Know
Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know

☐ Other-Specify _____

What is Your Race/Ethnicity?

☐ African American
☐ American Indian/Native American
☐ Ashkenazi Jewish
☐ Asian American
☐ Cajun/French Canadian
☐ Caucasian/ White
☐ Eastern European
☐ Hispanic/Caribbean
☐ Northern European
☐ Southern European
☐ Other: _____

Would you like to be screened for?

Cystic Fibrosis	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Tay - Sachs disease	☐ Yes	☐ No
Thalassemia	☐ Yes	☐ No

☐ Other_____

PLACE PATIENT LABEL HERE

SPOUSE / MALE PARTNER SIGNATURE	PRINT NAME	DATE	TIME

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME

I confirm that I have reviewed the information above.

Provider Notes (for office use only)_____

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