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____

PLACE PATIENT LABEL HERE

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

Disorder		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

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Neighborhood Clinics – Valley Medical Center
University of Washington Physicians Seattle, Washington

MALE FERTILITY HISTORY

U3734

UH3734 REV MAY 20

SPOUSE / MALE PARTNER SIGNATURE	PRINT NAME	DATE	TIME

I confirm that I have reviewed the information above.

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME

Provider Notes (for office use only)____

PLACE PATIENT LABEL HERE