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
Multiple Sclerosis ☐ Yes ☐ No
Prostate infection ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Other neurologic problems ☐ Yes ☐ No
Urinary infections ☐ 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
- ☐ AshkenaziJewish
- ☐ 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

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