CENTER FOR FERTILITY AND REPRODUCTIVE ENDOCRINOLOGY
MAGEE-WOMENS HOSPITAL

MALE INTAKE FORM

Patients - please complete both pages of this form

Today's Date: _____
month / day/ year

Name: _____ _____
Last *First*

Partner's Name: _____ _____
Last *First*

Reason for visit: □ Infertility □ Other _____

If trying to conceive, how long? □ Yes years _____

Please answer the following questions on both pages …

Make any comments in the comments section at the bottom of this page.

Numer of pregnancies with current partner: _____
Number of years married: _____ Years
Number of prior marriages: Husband: _____ Wife: _____
Number of pregnancies with previous partner (s): _____
Age (s) of children, if any _____

Past Medical History

Do you have any heart problems:	□ Yes	□ No
Do you have any lung problems? (asthma, etc.)	□ Yes	□ No
Do you have any bowel or stomach problems?	□ Yes	□ No
Problems with muscle or joints?	□ Yes	□ No
Ever had mumps?	□ Yes	□ No
Do you have any neurological problems?	□ Yes	□ No
Any hormonal problems? (thyroid,diabetes,etc.)	□ Yes	□ No

Do you have any other medical problems?

Have you had any surgery"

List medications you are now taking:

Allergy to medications: □ Yes □ No

Urological History		
Have you ever had undescended testicles:	□ Yes	□ No
Have you suffered an injury to the testicles?	□ Yes	□ No
Have you ever had a hernia repair?	□ Yes	□ No
Have you ever been diagnosed with varicocele?	□ Yes	□ No
Have you ever had a vasectomy?	□ Yes	□ No
Have you had bladder or prostate surgery?	□ Yes	□ No
Do you have a problem with achieving erections?	□ Yes	□ No
Have you had epididymitis?	□ Yes	□ No
Ever had a urinary tract infection?	□ Yes	□ No
Ever had a sexually transmitted disease?	□ Yes	□ No
Any problems with ejaculation?	□ Yes	□ No
Any problems with sex drive?	□ Yes	□ No
Did you have early puberty (before 12 yrs)?	□ Yes	□ No
Did you have late puberty?	□ Yes	□ No
Have you had abnormal sexual development?	□ Yes	□ No
Have you had a fever within the last 3 months?	□ Yes	□ No
Other family member have a fertility problem?	□ Yes	□ No

Social		
Any special exposure to heat on a regular	□ Yes	□ No
Basis (sauna, baths, Jacuzzi)?	□ Yes	□ No
Do you use recreational drugs?	□ Yes	□ No
Do you smoke?	□ Yes	□ No
Have you been exposed to any chemicals?	□ Yes	□ No
Have you been exposed to radiation	□ Yes	□ No
(not routine x-rays)?	□ Yes	□ No
How many drinks of alcohol per week?		

Comments on any of the above: _____

Reviewed by: _____ Date: _____

Patient name: _____ Date: _____

Family History

Has anybody in your family had any of the following?

Breast Cancer	□ Yes	□ No	Stillbirth	□ Yes	□ No	Tuberous sclerosis	□ Yes	□ No
Cystic Fibrosis	□ Yes	□ No	Muscular dystrophy	□ Yes	□ No	Tay-Sachs	□ Yes	□ No
Sickle-cell anemia	□ Yes	□ No	Down's syndrome	□ Yes	□ No	Mental retardation	□ Yes	□ No
Birth defects	□ Yes	□ No	Spina bifida	□ Yes	□ No	Thyroid disease	□ Yes	□ No
High blood pressure	□ Yes	□ No	Diabetes	□ Yes	□ No	Heart attack (<50 yrs)	□ Yes	□ No
Blindness	□ Yes	□ No	Psychiatric disease	□ Yes	□ No	Hemophilia	□ Yes	□ No
Polycystic kidneys	□ Yes	□ No	Deafness	□ Yes	□ No	Chromosome problem	□ Yes	□ No
Ovarian cancer	□ Yes	□ No	Bleeding disorders	□ Yes	□ No	Other genetic disorders	□ Yes	□ No

Ancestral Background

There are certain ancestral backgrounds that have an increased frequency of some diseases. Please indicate if either your mother or father are any of the following backgrounds:

□ African □ Caribbean □ Jewish □ Indian □ Asian □ French-Canadian
□ Latin-American □ Mediterranean □ Native American

This section to be completed by your Physician _____

Laboratory Results

Semen Analysis	**Date**	**Date**	**Date**	**Other test results**	
COUNT				FSH	
MOTILITY				LH	
MORPHOLOGY				PRL	
VOLUME				TESTO/FT	
Other Comments				TSH	

Physical Examination

GENERAL		□ Normal	□ Abnl.:		
ABDOMEN		□ Normal	□ Abnl.:		
PENIS		□ Normal	□ Abnl.:		
Meatus		□ Normal	□ Abnl.:		
TESTES	Left	□ Normal	□ Abnl.:		
	Right	□ Normal	□ Abnl.:		
VASA	Left	□ Normal	□ Abnl.:		
	Right	□ Normal	□ Abnl.:		
EPID	Left	□ Normal	□ Abnl.:		
	Right	□ Normal	□ Abnl.:		
PROSTATE		□ Normal	□ Abnl.:		
VARICO	Left	□ No	□ Mild	□ Mod	□ Large
	Right	□ No	□ Mild	□ Mod	□ Large

Other Finding _____

U/A: Dip □ Normal □ Abnl.:

PH: _____

Impression and plan:

_____

_____

_____

_____

_____

_____

Reviewed By: _____ ,M.D. Date: _____