



Date of initial Health Tx: \_\_\_\_\_

Update 1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

## Family Fertility Clinic - Male Fertility Form

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Patient's Name \_\_\_\_\_ Gender: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

PhoneNumber:(h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Email Address \_\_\_\_\_

Are you under the care of a physician now? \_\_\_Y\_\_\_N

If yes, for what? \_\_\_\_\_

Physician Name: \_\_\_\_\_ Tel: \_\_\_\_\_

In Emergency Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referred by: \_\_\_\_\_

Main Problem:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Treatments:

\_\_\_\_\_

Significant Illness:

\_\_\_\_\_

Surgeries (list):

\_\_\_\_\_

\_\_\_\_\_

Allergies:

\_\_\_\_\_

Major Trauma (car accident, fall, etc.)

\_\_\_\_\_

Are you currently taking any medicine? \_\_\_Y \_\_\_N

Please list: \_\_\_\_\_

Are you currently taking any non-prescribed medicine (for i.e. herbs, vitamins, supplements, etc.)?  
\_\_\_Y \_\_\_N

Please list: \_\_\_\_\_

Occupational Stress (chemical, Physical, psychological):

\_\_\_\_\_

Exercise: \_\_\_\_\_

Daily diet: \_\_\_\_\_

Habits: (please circle) Cigarettes    Alcohol    Soft drinks    Coffee    Tea

**Please describe or elaborate on the following questions:**

Pain – \_\_\_\_\_

Appetite – \_\_\_\_\_

Thirsty – \_\_\_\_\_

Energy – \_\_\_\_\_

Sleep – \_\_\_\_\_

Abnormal Sweating – \_\_\_\_\_

Skin and hair problems – \_\_\_\_\_

Bowel Movement – \_\_\_\_\_

Other digestive problems - \_\_\_\_\_

Urination – \_\_\_\_\_

Mood – \_\_\_\_\_

Headaches - \_\_\_\_\_

### Male Specific Questions

Have you ever had an undescended testicle?  
Have you ever been diagnosed with a varicocele?  
Have you ever had any urologic surgeries?  
Have you ever experienced erectile dysfunction?  
Have you ever experienced difficulty ejaculating?  
Have you ever had exposure to any known environmental toxins or hormones?  
Have you ever experienced any penile discharge?  
Do you regularly experience nocturnal emissions (wet dreams)?  
Do you have high cholesterol?  
Have you experienced a high fever in the last 6 months?  
Do you currently have any prostate conditions?  
Do you have or have you ever had any STD's?  
Have you ever taken testosterone supplements /drugs?  
Have you recently had your testosterone levels checked?  
Have you ever been diagnosed with small or soft testis?  
Have you ever been checked for a blockage of your reproductive tract?

Have you ever had a semen analysis?  
How many times?  
When was the last test?  
What was your sperm count? (millions)  
What was your sperm motility (%)  
What was your sperm morphology (% normal forms)  
What was the volume? (ml)  
How many days of abstinence did you have before the test?  
Other comments?

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Thank you for taking the time to fill out this form. All information is confidential and will not be released for legal or medical purposes without your consent.*

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