



The Nevada Center for Reproductive Medicine

MALE PATIENT HISTORY

Name _____

Are you, or have you ever, been exposed to any of the following during employment or military service? If so, explain:

Heat _____ Toxic Fumes _____

Chemicals _____ Nuclear Radiation _____

Other _____

What medications do you regularly take? (Prescription and/or over the counter drugs)

Do you frequently take saunas or steam baths? _____

Do you, or have you ever, used:

Alcohol? How many drinks per week? _____

Cigarettes? How many packs per day? _____

Illicit or recreational drugs? _____

Do you, or have you ever, had (circle all that apply):

Allergies? (Circle) Yes or No

If Yes, please list: _____

- Chronic Headaches
- Colitis
- Cystic Fibrosis
- Diabetes
- Dizziness
- Epilepsy
- Fever
- Gallbladder Problems
- Gonorrhea
- Heart Disease
- Hepatitis
- Herpes
- High Blood Pressure
- Kidney Infection
- Liver Problems
- Loss of Balance
- Measles : German
- Measles: Regular

- Mumps
- Mumps w/Testes Involved
- Neurological Problems
- Nongonococcal Urethritis
- Parasitic Infection
- Pneumonia
- Prostatitis
- Rheumatic Fever
- Scarlet Fever
- Seizures
- Syphilis
- Testes Infection
- Testes Injury
- Testes Tumor
- Thyroid Problems
- Tuberculosis
- Visual Disturbances
- Weight Loss

- Anemia
- Appendicitis
- Arthritis
- Blood Transfusions
- Breast Milky Discharge
- Breast Soreness
- Breast Tenderness
- Cancer (Specify) _____

- Chlamydia
- Chronic Bronchitis

Have you ever been treated for infertility in the past? _____

If yes, review diagnostic studies and treatments with our physician during your appointment.

Please list all types and dates of surgeries you have undergone: _____

