Vasectomy and Male Infertility Center of Connecticut

Fertility Patient Intake Form

Name: ____

Date: ____

Primary MD: ______________________________________

Referring MD: _____________________________________

How you heard about Dr. Matson:

Doctor Friend Radio Internet Wife

Please list all medical conditions:

None

1. ____
2. ____
3. ____
4. ____

Please list all medications taken daily:

None

1. ____
2. ____
3. ____
4. ____

Please list all surgeries you have had:

None

1. ________________________________ Date_____________
2. ________________________________ Date_____________
3. ________________________________ Date_____________
4. ________________________________ Date_____________

Please list family illnesses and relationship:

None

1. _________________________Relative_________________
2. _________________________Relative_________________
3. _________________________Relative_________________
4. _________________________Relative_________________

Please list all allergic triggers and reaction:

None

1. _________________________Reaction________________
2. _________________________Reaction________________
3. _________________________Reaction________________

Current type of work/profession:

____

Marital status:

Single Married Divorced Remarried

Fertility History

How many months have you and your current partner been trying to achieve a pregnancy? ____________

How old is your partner? ___________

Have you achieved pregnancy with your current partner in the past (circle)? N Y

If yes give outcome and date.

1. ________________________________ Date_____________
2. ________________________________ Date_____________
3. ________________________________ Date_____________
4. ________________________________ Date_____________

Has your partner been evaluated for infertility?

N Y (outcome_____________________________________)

Have your or your partner ever had sterilization?

N Y (details______________________________________)

Have you achieved pregnancy with any other partners?

N Y (details______________________________________)

Has your partner had pregnancies with someone other than you?

N Y (details______________________________________)

Sexual History

Rate your level of desire (circle):

←----very low---low---medium---high---very high----→

How many times per week do you have intercourse? _______

Do you ejaculate with intercourse? Y N

Do you ejaculate in your partner's vagina? Y N

How many times per week do you ejaculate? ________

How many times per week do you masturbate? _______

Do you have trouble getting or maintaining erection? Y N

Have you ever ejaculated with a flaccid (soft) penis? Y N

Do you ejaculate prior to penetration? Y N

Is intercourse painful for you? Y N

Do you use lubrication for intercourse (name)? ____________

Partners Sexual History

Rate your partners level of desire (circle):

←----very low---low---medium---high---very high----→

Does your partner get up after intercourse? ________

Does your partner experience pain with intercourse? Y N

Does your partner have regular menstrual periods? Y N

Has your partner or you learned to predict ovulation? Y N

Do you have sex every other day during ovulation? Y N

Has your partner ever had abdominal surgery?
Y N

Has your partner ever had?

Herpes	Y	N
Gonorrhea	Y	N
Pelvic Inflammatory Disease	Y	N
Chlamydia	Y	N

Specific Medical History:

Have you ever had the following conditions?

Arthritis	Y	N	Age ________
Bowel Disorder	Y	N	Age ________
Cancer	Y	N	Age ________
Change in body appearance?	Y	N	Age ______
Color Blindness	Y	N	Age ________
Deafness	Y	N	Age ________
Diabetes	Y	N	Age ________
Heart Problems	Y	N	Age ________
Hepatitis/Liver problems	Y	N	Age ________
High Blood Pressure	Y	N	Age ________
Indigestion/Ulcer	Y	N	Age________
Spinal disc/cord Problems	Y	N	Age ________
Breathing Problems	Y	N	Age ________
Thyroid Disease	Y	N	Age ________
Neurologic Disorder	Y	N	Age ________
Sickle Cell Disease	Y	N	Age ________
Sinus Problems	Y	N	Age ________
Tuberculosis	Y	N	Age ________

Fever > 101 in the past 3 months? Y N

Have you ever taken the following medications?

Allopurinol	Y	N	When? _____________
Antidepressants	Y	N	When? _____________
Antihypertensives	Y	N	When? _____________
Anti-parasitic agents	Y	N	When? _____________
Antipsychotics	Y	N	When? _____________
Cholesterol drugs	Y	N	When? _____________
Clomid	Y	N	When? _____________
Dilantin	Y	N	When? _____________
hCG injections	Y	N	When? _____________
Hormones	Y	N	When? _____________
Immunosuppressants	Y	N	When? _____________
Insulin	Y	N	When? _____________
Proscar or Propecia	Y	N	When? _____________
Tagamet (cimetidine)	Y	N	When? _____________
Zantac	Y	N	When? _____________

Specific Surgical History: Have you ever had surgery for the following?

Hernia	Y	N
Varicocele	Y	N
Hydrocele	Y	N
Prostate problems	Y	N
Undescended testicle	Y	N
Abdominal surgery	Y	N
Testicle problem	Y	N
Vasectomy	Y	N
Vasectomy reversal	Y	N
Penis surgery	Y	N
Prostate problems	Y	N

Specific Urologic History: Have you ever had?

Infection or swelling of the testicle	Y	N
Infection of the prostate	Y	N
Infection of the epididymis	Y	N
Gonorrhea	Y	N
Chlamydia	Y	N
Syphilis	Y	N
Herpes	Y	N
Herpes	Y	N
Mumps	Y	N
Had blood in the semen	Y	N
Pain with ejaculation	Y	N
White, green or yellow urethral discharge	Y	N

Endocrine History: Have you ever had?

Difficulty smelling Y N

Headaches Y N

Visual problems Y N

Change in energy level Y N

Poor sense of well being Y N

At what age did you develop armpit hair? ______________

At what age did you develop pubic hair? _______________

At what age did you start shaving your face? ____________

How often do you shave (circle)?

Twice per day Once per day Twice per day

Social History

Do you smoke? Y N How long? ______

How many cigarettes per day? _________

Do you use marijuana? Y N How long? ______

How many marijuana cigarettes per day? __________

Do you use alcohol? Y N

How many drinks per week? _______

More than 2-3 drinks in a 24-hour period? Y N

Do you use any of the following?

Cocaine Y N How long? ______

LSD Y N How long? ______

Amphetamines Y N How long? ______

Heroine Y N How long? ______

Methadone Y N How long? ______

Testosterone Y N How long? ______

Steroid use Y N How long? ______

Do you use saunas or hot tubs regularly? Y N

Do you use a laptop on your lap regularly? Y N

Have you had exposures to the following substances?

Prolonged heat Y N

Radiation Y N

Pesticides Y N

Solvents Y N

Heavy metals Y N

Toxins Y N

Family History

How many brothers do you have? _______

How many children do they have?

Brother #1_______ Brother #2_______

Brother #3 _______ Brother #4_______

Any have known fertility problems? Y N

How many sisters do you have? _______

How many children do they have?

Sister #1_______ Sister #2_______

Sister #3 _______ Sister #4_______

Any have known fertility problems? Y N

Was your mother given DES during pregnancy? Y N

Is there a family history of the following illnesses?

Birth defects? Y N

Cystic fibrosis Y N

Diabetes Y N

Hormone problems Y N

Kidney problems Y N

Lung disease Y N

Tuberculosis Y N

Other – Please use the space below to describe any other information or problems you feel Dr. Matson should know about.