Garrison Women's Health Center
"Supporting Women with Excellence and Compassion"
Obstetrics ~ Gynecology ~ Infertility ~ Midwifery
770 Central Avenue, Dover, NH 03820
Telephone (603) 742-0101

Male Infertility Intake Worksheet

Consult Date ___/___/_____

Name:_____ _____ Age:____ DOB:___/___/_____
Last *First*

Partner's Name:_____ _____ Age:____ DOB:___/___/_____
Last *First*

Primary Care Physician:_____ Occupation:_____

If trying to conceive, how long? ☐Yes ____Years

Have you had a semen analysis? ☐Yes ☐No Urological evaluation? ☐Yes ☐No

Please answer the following questions. Make any comments in the comment section below.

Number of pregnancies with current partner:____
Number of years married:____
Number of prior marriages: Husband:_____ Wife:____
Number of pregnancies with previous partner(s):____
Ages 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 bowel or stomach problems? ☐Yes ☐No
Do you have bowel or stomach problems? ☐Yes ☐No
Problems with muscles or joints? ☐Yes ☐No
Ever had mumps? ☐Yes ☐No
Do you have neurological problems? ☐Yes ☐No
Hormonal problems? (thyroid, diabetes) ☐Yes ☐No
Other medical problems?
_____
_____
_____

Have you had any surgery?
_____
_____
_____

Current medications, including herbs/supplements:
_____
_____

ALLERGY to medications:☐No ☐Yes:_____
_____

Urological History

Undescended testicles? ☐Yes ☐No
Injury to testicles? ☐Yes ☐No
Hernia repair? ☐Yes ☐No
Varicocele? ☐Yes ☐No
Vasectomy? ☐Yes ☐No
Bladder or prostate surgery? ☐Yes ☐No
Problem achieving erections? ☐Yes ☐No
History of epididymitis? ☐Yes ☐No
Urinary tract infections? ☐Yes ☐No
Sexually transmitted disease? ☐Yes ☐No
Problems with sex drive? ☐Yes ☐No
Early puberty (before age 12)? ☐Yes ☐No
Late puberty? ☐Yes ☐No
Abnormal sexual development? ☐Yes ☐No
Fever within the last 3 months? ☐Yes ☐No
Other family members with fertilty problems? ☐Yes ☐No

Social History

Any special exposure to heat on a regular basis? (sauna, baths, Jacuzzi, etc)? ☐Yes ☐No
Recreational drug use? ☐Yes ☐No
Do you smoke? ☐Yes ☐No
Exposure to chemicals? ☐Yes ☐No
Exposure to radiation? (Not routine x-rays) ☐Yes ☐No
How many alcoholic drinks/wk:_____

*Comments on any of the questions to which you answered "Yes":*_____