SAN DIEGO Fertility Center

www.sdfertility.com
www.eggdonors.com

Male Medical History

Last Name	First Name	Date of Birth		
		Year	Day	Month

Height		Weight		Age	

Marital Status	Single	1st Marriage	2nd Marriage	Other

Fertility History

Have you fathered any pregnancies? Please list number and outcome	.
Do you have any children? If yes, what are their ages?	
How long have you been trying to conceive?	
How often do you typically have intercourse per week?	
Additional Info	

Fertility Evaluation

Please list any results of previous infertility evaluation you have completed. Please list dates if possible.

Semen Analysis	
Other Results	

Fertility Treatment History		
Cycle Type	**Date**	**Outcome**

Past Medical History	
Please list your medical problem.	
List any surgeries you have had.	
Have you ever had a vasectomy? If yes, have you had a reversal?	
Have you ever had any testicular surgery or injury?	
Do you have any difficulty forming an erection, with masturbation, or producing for a clinic?	
Do you have any ejaculatory dysfunction?	
Have you experienced low libido or increased fatigue?	
Are you taking any medication? Please list.	
Please list any testosterone therapy or steroids for body building you have taken.	
Are you allergic to any medications? Please list. Please describe your reaction.	
Do you have a latex allergy?	

Social History	
Have you ever smoked? For how long?	
Do you smoke currently? How much do you smoke currently?	
How many alcoholic drinks do you consume per week?	

How many Caffeinated drinks do you consume per week?	
Do you use marijuana or other drugs? If yes, please list type and frequency.	
Occupation	

Family & Genetics History

Ethnic Background:
Please mark all that apply.

	Southeast Asia, Taiwan, China, or the Philippines
	Italy, Greece, or the Middle East
	Eastern European (Ashkenazi) Jewish or French Canadian
	African American, African, or Black

If you are adopted and do not know any family history regarding either of your biological parents, you do not need to complete the family history section below.

	I am adopted

Family History:

Has anyone in your family been affected by the following conditions?

Please mark all that apply and list any additional details.

	Down Syndrome		Other Nerve, Muscle or Seizure Disorder (e.g. epilepsy)
	Other Chromosome Abnormalities		Phenylketonuria (PKU)
	Neural Tube Defect (e.g. spina bifida, anencephaly)		Kidney Disease
	Hemophilia or Other Bleeding Disorders		Heart Defect (from birth)
	Cystic Fibrosis		Cleft Lip and/or Cleft Palate
	Sickle Cell Anemia		Limb Defects (extra or missing digits, malformed arms, legs, hands or feet)
	Thalassemia (Mediterranean anemia)		Deafness / Early Onset Hearing Loss
	Tay Sach's Disease		Blindness / Early Onset Vision Loss
	Muscular Dystrophy		Diabetes
	Neurofibromatosis		Cancer before age 50

	Huntington's Disease		Heart Attack before age 40
	History of still birth or 3 or more first trimester miscarriages		History of neonatal death
	Blood clotting disorders?		Stroke, pulmonary embolus, deep vein thrombosis
	Are you and your partner related in any way? (ex: cousins?)		Mental Retardation or developmental Delay
	Genetic defect or chromosome abnormality not listed: please describe:		Any other family history you are concerned about: