# **MALE INFERTILITY HISTORY**

This is a confidential document, which will be used only for your treatment. Please obtain copies of pertinent medical records to bring to your first appointment with Dr. Pattinson. Note: **couples referred for infertility must attend their first appointment together and must both have valid current OHIP cards with photo id in order to be seen**.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_

# Wife / Partner’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you fathered any pregnancies in the past? Yes / No

If yes, please give details (dates, pregnancy outcomes – normal baby, miscarriage, abortion etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been trying to have a baby? \_\_\_\_\_\_\_\_ yrs

How long have you been with this partner? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you shave: Daily/Every other day/Twice weekly/Weekly/Less often/Bearded

Do you have any problems: Getting or maintaining an erection yes / no

With ejaculation yes / no

Have you experienced: Pain on ejaculation yes / no

Blood in the urine or the ejaculate yes / no

Have you had mumps Yes / No How old were you? \_\_\_\_\_\_\_\_ yrs

Have you had: Injury or trauma to the penis, scrotum or testicles? yes / no

Surgery to the penis, scrotum or testicles yes / no

A sexually transmitted (venereal) disease or hepatitis yes / no

Have you ever been referred to a urologist? yes /no

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exposed to any fumes, chemicals or other environmental agents which you feel may be affecting you fertility? Yes / no

If you have answered yes to any of these questions, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following tests to investigate your fertility problem?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Test | Yes/No/Not sure | When | Doctor | Result (Normal / Abnormal) – describe if possible. |
| Sperm count # 1 |  |  |  |  |
| Sperm count # 2 |  |  |  |  |
| Ultrasound of the testes |  |  |  |  |
| Hormone Blood tests |  |  |  |  |
| Biopsy of the testis |  |  |  |  |

Do you have, or have you had, any long term illness, or any other medical condition that you have required treatment or medication for? Yes / No

If yes, please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had surgery? If yes, give details

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Hospital | Surgeon | Procedure |
|  |  |  |  |

# Do you smoke? Yes / No. If yes, How much? \_\_\_ /day or \_\_\_ / month

# Do you drink alcohol? Yes / No If yes, How much? \_\_\_ /day or \_\_\_ / month

How many caffeine containing drinks do you consume daily (coffee, cola etc) \_\_\_\_\_

Are you taking any medications, natural remedies, body building agents or vitamins? Yes / No

If yes, please describe which drugs and how often you use them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any street drugs? Yes / No

If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Has there been any abuse in your current or past relationships? Yes/no, if yes please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# What is your Height? \_\_\_\_\_\_\_\_\_\_\_Weight? \_\_\_\_\_\_\_\_\_\_\_\_BMI?\_\_\_\_\_\_\_\_\_\_

Please feel free to add any further information.

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**Patient Instructions for Semen Collection – Fertility Testing**

If you have not had a sperm count done in the 6 months prior to your appointment, please bring a semen sample to your first appointment with Dr. Pattinson.

1. Do not have sex or masturbate for 48 hours before collecting the sample.
2. Abstain form sex or masturbation for no more than 7 days before collecting the sample.
3. Use an appropriate container. This can be obtained at our office or at any lab. Specimen containers other than those provided are unacceptable for collection and will be rejected.
4. Produce the sample by masturbation collecting the entire ejaculate into the container. Do not use a sheath or condom for collection as they are harmful to sperm.
5. Seal the container immediately after collection and make sure the lid is on correctly and tightly.
6. The specimen should be kept at body temperature by carrying it close to the body until it is dropped off at the laboratory.
7. The specimen should be delivered to the laboratory within one hour of collection.

In addition, please do the blood work at least 2 weeks prior to your appointment date. You may have the blood drawn at Dr Pattinson’s office or at any lab.