Patient's Name: _____ DOB: _____

**MALE**
**New Patient Fertility Information Sheet**

1. How long have you been trying for a pregnancy (unprotected sex)? _____
2. Are you married/do you have a significant other? YES NO
3. Any pregnancies in the past with current partner/spouse? _____
    a. Any pregnancies with prior partner/spouse? _____
4. How long have you and your current partner/spouse been together? _____
5. Do you have any biological children of your own? _____
    a. Are these children with your current partner/spouse? _____
6. How often do you have intercourse in a week? _____
7. Do you have any problems with erections or ejaculations? YES NO
    a. If yes, have you tried treatments? Have they helped? _____
8. Have you had any exposure to chemicals (chemotherapy/radiation) in the past? _____
9. Any prior semen testing? YES NO
    a. If yes, when was the test performed? _____
    b. Where was the test performed? We may need to pull those records.

    _____
10. Have you ever been on testosterone? YES NO
    a. If yes, what type (injections, gel, pellets), for how long, and what dose? _____

    _____
11. Any surgeries on your scrotum, penis, prostate, or a hernia? YES NO
12. Do you have a history of undescended testicles as a child? YES NO
13. Are there any males in the family with fertility issues? YES NO