

RUTEK CENTER FOR REPRODUCTIVE MEDICINE, P.A.

Please complete to the best of your knowledge, print clearly in ink

New Patient Medical Health History Questionnaire (Male)

Name: _____ Today's Date: _____

Primary Care Physician: _____ Referred by: _____

Age: _____ Date of Birth: _____ Marital Status: _____

Occupation: _____

Reason for Visit: _____

PAST MEDICAL HISTORY

Do you have or have you ever had any of the following? (Please check all that apply)

Condition	Yes	No	Unsure	Condition	Yes	No	Unsure
AIDS or positive HIV test				Erectile Dysfunction			
High Blood Pressure				Anemia/Thalassemia			
Diabetes				Birth defects			
Heart Disease				Mumps			
Lung Disease				Gonorrhea			
Liver problems				Chlamydia			
Kidney problems				Sickle cell disease or trait			
Mental illness				Tuberculosis			
Seizures/epilepsy				Cystic Fibrosis			

Are you under a physician(s) care? ___ Yes ___ No If yes, please give name (s) and specify condition treated

Additional Comments

Past Surgical History

Have you had any of the following procedures?

Hernia repair ___ No ___ Yes Date _____

Fixation of testicular torsion ___ No ___ Yes Date _____

Reversal of vasectomy ___ No ___ Yes, Date _____

Surgery for varicocele ___ No ___ Yes,
Date _____

List other surgeries _____

Have you had any of the following tests? If yes, list any results and dates of tests

Syphilis: ___ No ___ Yes, Date _____ Negative Positive

HIV: ___ No ___ Yes, Date _____; Negative Positive

Hepatitis B & C: ___ No ___ Yes, Date _____ Negative Positive

Blood Type: ___ No ___ Yes,
Date _____ Result _____

Cystic Fibrosis: ___ No ___ Yes, Date _____ Negative Positive

Hemoglobin Electrophoresis: ___ No ___ Yes, Date _____ Normal Abnormal

Semen Analysis:

Date: _____ **Place:** _____

Results: _____

List allergies to medications: _____

List current medications: _____

List current over the counter medicines, vitamins and food supplements that you take
_____ None

1) _____

2) _____

3) _____

4) _____

Social History:

Do you smoke cigarettes? ___No ___Yes; If yes, number of packs/day and years of use:

Do you drink alcohol? ___ No ___Yes; If yes, glasses/day:_____

Do you use marijuana, cocaine or similar drugs? ___No ___Yes; If yes, list drugs_____

Do you inject drugs intravenously? ___No ___Yes; If yes, list drugs_____

Number of life sexual partners: _____

Do you exercise regularly? ___No ___Yes; If yes, How often/How much: _____
Describe your diet_____

How long with current partner?_____

How will you describe yourself? ___Caucasian; ___African American; ___Ashkenazi
Jewish; ___ Hispanic; ___Asian; ___Other (specify_____)

Would you like to be screened for?

Cystic Fibrosis _____Yes _____No
Sickle Cell Anemia _____Yes _____No
Tay-Sachs Disease _____Yes _____No
Thalasemia _____Yes _____No

FAMILY HISTORY

Paternal Ancestry

Father's age (if living)	_____	Health status:	_____
If deceased, age at death	_____	Cause of death:	_____
Paternal grandfather's age (if living)	_____	Health status:	_____
If deceased, age at death	_____	Cause of death:	_____

Paternal Aunts and Uncles, Living	Sex	Age	Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Paternal Aunts and Uncles Deceased	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____

Paternal First Cousins,	Sex	Age	Birth defect/Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____

Maternal Ancestry

Mother's age (if living)	_____	Health status: _____
If deceased, age at death	_____	Cause of death: _____
Maternal grandfather's age (if living)	_____	Health status: _____
If deceased, age at death	_____	Cause of death: _____
Maternal grandmother's age (if living)	_____	Health status: _____
If deceased, age at death	_____	Cause of death: _____

Maternal Aunts and Uncles, Living	Sex	Age	Health Status_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Maternal Aunts and Uncles Deceased	Sex	Age at Death	Cause of Death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Brothers and Sisters	Sex	Age	Health Status
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Deceased siblings	Sex	Age at Death	Cause of Death
_____	---	_____	_____
_____	---	_____	_____

Children with previous partners	Sex	Age	Health Status
_____	---	---	_____
_____	---	---	_____
_____	---	---	_____

Deceased children	Sex	Age	Cause of Death
_____	---	---	_____
_____	---	---	_____

Additional Comments
