JONES INSTITUTE FOR
REPRODUCTIVE MEDICINE

Patient Questionnaire (Male) PLEASE USE BLACK INK ONLY

This form is designed to provide information to those of us involved in your health care. Please answer these questions as well as you can. We will review this with you during your physical examination.

Date: _______________ Social security number: __________________________________

Name: __________________________________ Date of birth: ________________________

Address: ____
Street city state/zip

Home phone: (___)_____________________ Hours at this number: _________________

Work phone: (___)_____________________ Hours at this number: _________________

Occupation: ____

Race (optional): ____

Name of family doctor/referring Physician: ____

Address: ____

Marital status: Single ☐ Separated ☐ Engaged ☐
Married ☐ Divorced ☐ Widowed ☐

Spouse/Partner's full name: ___________________________Date of birth: __________________

Spouse/Partner's occupation: ____

Number of year married (if applicable): _____________Number of children: ________________

Emergency contact: ____
(Person not living in household) Relationship

Phone number: ____________________________ _____________________________________
Day Evening

Address: ____
Street City State/Zip

For what reason are you consulting the physician today?

____

Physician signature:_______________________________________Date:______________________

Chief Complaint (reason why you are here):

____
____

Have you ever had a semen analysis? When/where? ______________________________
Results? ____
Have you been previously evaluated for infertility? Yes/no When? ___________________
Doctors Name ____
How long have you been trying to achieve pregnancy with your current partner?____
Have you fathered a pregnancy in the past? Yes/no Current partner? Number of children? ____________ Previous partner? Number of children _______________
Do you have any allergies to any medications? If so, please list: ______________________
____

What medications do you currently take, and what medications have you taken in the past year?
Current: ____
Past: ____

Do you use: tobacco? yes/no amount: ____
alcohol? yes/no amount: ____
recreational drugs? yes/no If so, please list: ___________________________

What pharmacy do you use? ____
Pharmacy address: ____
Pharmacy phone number: ____
Pharmacy Fax number: ____

Are you exposed to any toxins, chemicals, solvents, etc., at your job? If so, please list:
____
____

Medical/Family History

Problem	Self	Mother	Father	Sibling	Grandparents
Arthritis					
Bleeding disorder					
Cancer					
Heart Disease					
High Blood Pressure					
Hepatitis					
HIV infection					
Diabetes					
Thyroid Disease					
Kidney Disease					
Gastrointestinal Disease					
Disease of Nervous System					
Mumps					
Headaches					
Visual problems					
Other					

Comments: ____
____

Urology History

Hernia	Yes/No
Hydrocele	Yes/No
Varicocele	Yes/No
Vasectomy	Yes/No
Undescended testes	Yes/No
Testicular Biopsy	Yes/No
Breast enlargement or pain	Yes/No
Growth problems	Yes/No
Prostate disease	Yes/No
Urinary Tract Infections	Yes/No
Other	Yes/No

Comments: ____
____

STD History---Have you or your partner ever been diagnosed with any of the following? If "yes", please provide a comment below.

Problem	Self	Partner
Herpes	Yes/No	Yes/No
Pelvic Inflammatory disease	Yes/No	Yes/No
Gonorrhea	Yes/No	Yes/No
Chlamydia	Yes/No	Yes/No
Urethritis	Yes/No	Yes/No
Syphilis	Yes/No	Yes/No
Condyloma (warts)	Yes/No	Yes/No
HIV	Yes/No	Yes/No

Comments: ____
____
____

Sexual History – check if you have ever had any of the following:

Dry ejaculation	Yes/No
Low volume ejaculation	Yes/No
Painful ejaculation	Yes/No
Bloody ejaculation	Yes/No
Premature ejaculation	Yes/No
Difficulty maintaining erection	Yes/No
Difficulty obtaining an erection	Yes/No
Difficulty with ejaculating in the vagina	Yes/No
How many times per week do you have intercourse?	

Comments: ____
____
____

Patient signature:______________________________Date:____________________