



South Jersey Fertility Center

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Male Partner History Questionnaire

1/09

Name: _____ Date of Birth: _____

Nickname or Name you liked to be call: _____

Name of Female Partner: _____

FERTILITY PARTNER HISTORY (Please answer this section if you wish to conceive now or in the near future)

1. What is your occupation (if applicable)? _____
2. How long have you been in this current relationship? _____
3. Have you conceived a pregnancy with your current partner? _____
4. Did you ever try to conceive a pregnancy in a previous relationship? _____
5. Have you fathered any pregnancies in a previous relationship? _____
6. Have you seen a urologist for fertility evaluation? _____
7. Did you receive treatment from a urologist? _____
8. Have you had a semen analysis? _____ Result: _____
9. Do you suffer any erectile/ejaculatory difficulties? _____
10. Did you have the mumps after puberty? _____
11. Have you ever had a sexually transmitted disease (e.g. gonorrhea, chlamydia, syphilis, herpes, trichomonas)? _____

12. Have you suffered significant trauma to your testicles? _____
13. How many cigarettes do you smoke per day? If none, then state none. (List cigars here separately)

14. How much alcohol do you consume in a typical week? If none, then state none.

15. Have you used marijuana or other illicit drugs in the past year? (please list here)

16. Have you used anabolic (body building) steroids (sometimes used by athletes)? _____
17. Do you have exposure to toxic chemicals or radiation? _____
18. List any medical diagnosis you have (e.g. thyroid disorder, high blood pressure, diabetes, depression, history of hepatitis): _____

19. List any surgeries that you have had, particularly of the testicles, prostate or groin area and other surgeries such as of the appendix, gallbladder, spine, etc.

20. List your medications and their doses: _____

21. List any allergies to medications and your reaction. _____
22. What is your blood type? (Write unknown if you are unsure) _____
23. Is there a history of birth defects or genetic diseases in your family? (e.g. Down's Syndrome, Sickle Cell Anemia, mental retardation, Cystic Fibrosis)

24. Family Heritage: Circle all that apply or write in other categories.
Caucasian, Jewish, African American, Hispanic, Italian, Greek, Filipino, Indian/Pakistani, Middle Eastern, Asian, Other: