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New Patient Medical History Form : Male

Name: _____ Age: _____

Height: _____ Weight: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ De Facto ☐ Divorced ☐ Separated ☐ Other

Ethnicity: _____

Allergies: _____

Current Medications: _____

Supplements/ Vitamins: _____

Reason for visit: _____

_____

How many caffeinated beverages (soft drink, tea, coffee, etc.) do you drink per day? _____

Do you smoke? ☐ No ☐ Yes _____ / packs per day. Have you quit? When?
_____

Do you drink alcohol? ☐ No ☐ Yes _____ / standard drinks per week.

Do you use any recreational drugs? ☐ No ☐ Yes - Specify: _____

_____

Do you exercise: ☐ No ☐ Yes - How often? _____

Have any of you immediate family members had difficulty conceiving a child? ☐ No ☐ Yes

Have you fathered any pregnancies? ☐ No ☐ Yes - How many? _____

If you selected Yes above, were the pregnancies with another woman? ☐ No ☐ Yes

Are you aware of any radiation/toxic materials exposure? ☐ No ☐ Yes

Are you exposed to any radiation or harmful chemicals in the workplace? ☐ No ☐ Yes

Do you use hot tubs regularly? ☐ No ☐ Yes

Medical & Surgical History

Have you ever had a semen analysis? ☐ No ☐ Yes - Please provide a copy of the results.

Have you ever been diagnosed with a sexualy transmitted disease? ☐ No ☐ Yes

Have you had a history of undescended testicles? ☐ No ☐ Yes

Do you have scrotal or testicular pain? ☐ No ☐ Yes

Did you have the mumps after puberty? ☐ No ☐ Yes

Have you had prior injury to your testicles requiring hospitalisation? ☐ No ☐ Yes

Have you had a vasectomy? ☐ No ☐ Yes - Have you had a vasectomy reversal? ☐ No ☐ Yes

Do you have any medical conditions? ☐ No ☐ Yes - Specify: _____

_____

Have you had any fever in the last 3 months? ☐ No ☐ Yes - Specify: _____

Do you know your blood type? ☐ No ☐ Yes - Specify: _____

Did you have any childhood illness? ☐ No ☐ Yes - Specify: _____

_____

Have you ever had any surgery? ☐ No ☐ Yes - Specify: _____

_____

Did you have any anaesthesia problems? ☐ No ☐ Yes

Family History

Any relevant medical family history? ☐ No ☐ Yes - Specify: _____

_____

_____

_____

Vaccinations

Have you been vaccinated against the below?

Chickenpox (Varicella):	☐ Yes	☐ No	☐ Don't know
MMR - Measles, Mumps and Rubella:	☐ Yes	☐ No	☐ Don't know
Hepatitis A:	☐ Yes	☐ No	☐ Don't know
Hepatitis B:	☐ Yes	☐ No	☐ Don't know
Polio:	☐ Yes	☐ No	☐ Don't know
Whooping Cough:	☐ Yes	☐ No	☐ Don't know
Influenza:	☐ Yes	☐ No	☐ Don't know