California Center *for* REPRODUCTIVE MEDICINE

# Lori Arnold, M.D., F.A.C.O.G
# Reproductive Endocrinology and Fertility

## NEW PATIENT HISTORY

## A. MALE IDENTIFYING DATA

Date this form completed _______________

Your name: _ Age _ Partner's name:________________________________

Have you seen a doctor for infertility evaluation? ________________________________________________

Doctor ________________________________________________

Diagnosis ________________________________________________

Treatment ________________________________________________

## B. FERTILITY HISTORY

| Have you had: | Not Done | Result: Normal | Result: Abnormal | Approx date | Values (if known) |
|---|---|---|---|---|---|
| Semen analysis | ☐ | ☐ | ☐ | ___________ | ________________ |
| Hamster egg penetration assay | ☐ | ☐ | ☐ | ___________ | ________________ |
| Semen antisperm antibodies | ☐ | ☐ | ☐ | ___________ | ________________ |

Comments: ________________________________________________

**Pregnancies from previous marriage(s) or partner(s), if any:**

| Pregnancy (include all pregnancies) | When ? (Year) | How long to conceive | Sex and weight | Outcome (miscarriage, abortion, ectopic, vaginal delivery, cesarean section, stillbirth, complications if any. |
|---|---|---|---|---|
| First | | | | |
| Second | | | | |
| Third | | | | |
| Fourth | | | | |
| Fifth | | | | |

Comments: ________________________________________________

C: MEDICAL HISTORY

**Serious or chronic illnesses or injuries:**

| Date | Illness/Injury | Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Comments: ______________________________________________

Do you have or have you had:

| | Yes | No |
|---|---|---|
| Antichlamydial antibodies | ☐ | ☐ |
| Chlamydia | ☐ | ☐ |
| Gonorrhea | ☐ | ☐ |
| Syphilis | ☐ | ☐ |
| Genital herpes | ☐ | ☐ |
| Mycoplasma | ☐ | ☐ |
| Nongonococcal Urethritis | ☐ | ☐ |
| Ureaplasma | ☐ | ☐ |
| Urethritis/epididymitis | ☐ | ☐ |
| | ☐ | ☐ |
| Abdominal surgery | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Biopsy of the testicles | ☐ | ☐ |
| Bladder/kidney infections | ☐ | ☐ |
| Bleeding disorders | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Chronic bronchitis | ☐ | ☐ |
| Colitis | ☐ | ☐ |
| Cystic fibrosis | ☐ | ☐ |
| DES exposure in the womb | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Eating disorder | ☐ | ☐ |
| Ejaculation problems | ☐ | ☐ |
| Erection problems | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Excess stress | ☐ | ☐ |
| Gallbladder problems | ☐ | ☐ |
| Heart disease | ☐ | ☐ |
| Hepatitis A, B or C | ☐ | ☐ |
| Hernia surgery | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |
| Kidney disease | ☐ | ☐ |
| Kidney infection | ☐ | ☐ |
| Liver problems | ☐ | ☐ |
| Lung disease | ☐ | ☐ |
| Lupus | ☐ | ☐ |
| Migraine headaches | ☐ | ☐ |
| Mumps with injury to the testicles | ☐ | ☐ |
| Painful swelling of the testicles | ☐ | ☐ |
| Penile discharge or pain | ☐ | ☐ |
| Poor sense of smell | ☐ | ☐ |
| Prostatitis | ☐ | ☐ |
| Psychiatric treatment | ☐ | ☐ |
| Radiation exposure | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Thyroid disease | ☐ | ☐ |
| Torsion (twisted) | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Undescended testicle | ☐ | ☐ |
| Varicocele | ☐ | ☐ |
| Varicocele surgery | ☐ | ☐ |
| Vasectomy | ☐ | ☐ |
| Vasectomy reversal | ☐ | ☐ |
| | ☐ | ☐ |

Other ______________________________________________

If yes, please explain: ______________________________________________

LORI L. ARNOLD, M.D., F.A.C.O.G. | Medical Director | Board Certified Reproductive Endocrinology & Fertility

477 North El Camino Real • Suite C-310 • Encinitas, CA 92024 • tel: 760.274.2000 • fax: 760.274.2006 cacrm.com

**Medications: Please list all prescriptions and over-the-counter drugs used during the past year.**

| Medication | Dosage and frequency | From when to when | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Allergies**

| To what (drug or substance)? | When | What type of reaction? |
|---|---|---|
| | | |
| | | |
| | | |

D. PAST SURGICAL HISTORY

**Operations and Hospitalizations**

| Date | Diagnosis | Operation | Where performed | Physician | Complications of anesthesia |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Comments: ______________________________________________________________

E. FAMILY HISTORY

Ethnic background (circle): African/American Asian Asian-Indian Caucasian

Hispanic Jewish Indian Mediterranean Middle Eastern Other __________________

| Ethnic group (Circle all that apply) | Have you been tested for: | Yes | No | Date | Result |
|---|---|---|---|---|---|
| African, African/American | Sickle cell trait | | | | |
| Asian, Mediterranean or Hispanic | Thalassemia | | | | |
| Caucasian, Jewish | Cystic fibrosis | | | | |
| Jewish | Tay Sachs | | | | |
| Jewish | Gaucher | | | | |

Are you related to your partner (consanguinity)? ______________________________

Comments: ____________________________________________________________________

Is there anyone in your family who has had any of the following?

| | Yes | Who | | Yes | Who |
|---|---|---|---|---|---|
| Abnormal breasts | | | Infertility | | |
| Birth defects | | | Lack of sense of smell | | |
| Bleeding disorders | | | Learning problems | | |
| Chromosomal disorders | | | Mental retardation | | |
| Connective tissue disease | | | Metabolic disorders | | |
| Cystic fibrosis | | | Miscarriages (2 or more) | | |
| Delayed development | | | Muscular dystrophy | | |
| Down's syndrome | | | Short stature | | |
| Early puberty | | | Spina bifida | | |
| Genetic (inherited disorders) | | | Stillborn child | | |
| Genital abnormalities | | | Testicular cancers | | |
| Hemophilia | | | Undescended testicles | | |
| Hormonal disorders | | | Other | | |

Other ________________________________________________________________________

F. SOCIAL HISTORY:

Cigarettes – packs smoked/day ________________________________________________

Alcohol – type and number of drinks/week ______________________________________

Marijuana – amount __________________________________________________________

Other drugs – type and amount ________________________________________________

Ever used intravenous drugs? _________________________________________________

Trauma to the testicular area _________________________________________________

Toxic exposure (pesticides, radiation) __________________________________________

Excess heat to the testicular area ______________________________________________

Strenuous exercise __________________________________________________________

Tight underwear ____________________________________________________________

Hot tub or sauna use ________________________________________________________

Please use the remainder of this page to explain any additional information you think the doctor may need.

LORI L. ARNOLD, M.D., F.A.C.O.G. | Medical Director | Board Certified Reproductive Endocrinology & Fertility

477 North El Camino Real • Suite C-310 • Encinitas, CA 92024 • tel: 760.274.2000 • fax: 760.274.2006 cacrm.com