

UC Center for Reproductive Health

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Male History Form

(Complete with your male partner if applicable)

1. IDENTIFYING INFORMATION

Name _____

Date this form was completed ____/____/____

DOB ____/____/____ Age _____

2. PREGNANCY HISTORY (that you have been responsible for) None

| 1. | Date | Mis-carriage? | Elective Abortion? | Months to conceive? | Infertility Treatment? | Weight and sex? | Complications? |
|----|------|---------------|--------------------|---------------------|------------------------|-----------------|----------------|
| 1. | : | : | : | : | : | : | : |
| 2. | : | : | : | : | : | : | : |
| 3. | : | : | : | : | : | : | : |

3. OPERATIONS AND HOSPITALIZATIONS

| Date | Reason and type of surgery | Where | Physician |
|------|----------------------------|-------|-----------|
| 1. | : | : | : |
| 2. | : | : | : |
| 3. | : | : | : |

4. MEDICAL HISTORY

Do you have or have you had?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rubella | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis / liver disorder | <input type="checkbox"/> Prostatic infections | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Serious injury / accident | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Colitis / enteritis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Recent immunization |

Any medical problem not listed above (please list type, dates, treatments)

1. _____
2. _____

5. MEDICATIONS List all prescriptions and over-the-counter drugs used during the past year.

| Date | Dose and frequency | From when to when | Reason |
|------|--------------------|-------------------|--------|
| 1. | : | : | : |
| 2. | : | : | : |
| 3. | : | : | : |

10. ETHNICITY *Data will be used for genetic testing recommendation purposes

- Caucasian
 Hispanic
 Asian
 African American
 Other (_____)

Do you or anyone in either family have?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Neural tube defects/spina bifida/anencephaly | <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Tay-Sachs disease <input type="checkbox"/> Sickle cell disease or trait | <input type="checkbox"/> Chromosomal disorder <input type="checkbox"/> Genetic / inherited disorder |
| <input type="checkbox"/> Thalassemia <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Huntington chorea <input type="checkbox"/> Mental retardation / fragileX | <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hormonal disorder | <input type="checkbox"/> Baby with birth defects <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Stillbirth | <input type="checkbox"/> Epilepsy or seizures <input type="checkbox"/> Phenylketonuria | <input type="checkbox"/> Kidney disease <input type="checkbox"/> Neurofibromatosis | <input type="checkbox"/> Mental illness <input type="checkbox"/> Myotonic dystrophy |
| <input type="checkbox"/> 3 or more miscarriages | <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Any birth defects? | <input type="checkbox"/> Any inherited disorders? | | |

Please explain a "Yes" answer to any of the above _____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background.

You may be offered additional screening based on your ethnicity. Are you: African-American Yes No
Ashkenazi Jewish Yes No Mediterranean/Asian/French Canadian Yes No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

11. HISTORY OF FERTILITY THERAPY (Fill out, if applicable)

Have you been treated for infertility previously? YES NO If yes, who was your physician?
What cause of infertility was diagnosed?

What medications have you taken for infertility?
Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:
 Semen Analysis When ____/____/____ Results
 Chromosomes When ____/____/____ Results
 Genetic screening When ____/____/____ Results
 OTHER _____

PARTNER'S SIGNATURE

DATE

I confirm that I have reviewed the above information.

PHYSICIAN'S SIGNATURE

DATE

Welcome and we look forward to working with you.
Please write down any specific concerns you want to review at your visit.

Thank you - The UC Center for Reproductive Health Team