

# Scott Roseff, MD, F.A.C.O.G

10115 Forest Hill Blvd  
Suite 401A  
Wellington, Florida 33414  
561-333-8232  
Fax: 561-333-8242

## PART I: CONTACT INFORMATION

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ LMP: \_\_\_\_\_ Age \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address and Phone: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Indicate which number to call or leave messages.

Home Telephone ( ) \_\_\_\_\_  Work ( ) \_\_\_\_\_  Cell ( ) \_\_\_\_\_

Are you married?  Yes  No  Divorced  Other: \_\_\_\_\_

Spouse/Male Partner's  Not Applicable

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ S.S.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Occupation: \_\_\_\_\_

Indicate which number to call or leave messages.

Home Telephone ( ) \_\_\_\_\_  Work ( ) \_\_\_\_\_  Cell ( ) \_\_\_\_\_

Who referred you?

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Former Patient/Friend \_\_\_\_\_  Other \_\_\_\_\_

Who is your Ob/Gyn? Name \_\_\_\_\_ Phone \_\_\_\_\_

Who is your Primary Care Physician? Name \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insured's Name \_\_\_\_\_ DOB: \_\_\_\_\_ S.S.# \_\_\_\_\_

**PART II: FEMALE MEDICAL HISTORY AND INFORMATION**

Reason for Visit:  Infertility Evaluation  Sperm Insemination  Other \_\_\_\_\_

What are your expectations for this visit? \_\_\_\_\_

What questions do you want answered at this visit? \_\_\_\_\_

Do you have any personal, ethical, or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.?  
 No  Yes \_\_\_\_\_

How many months have you been having intercourse without using any form of birth control? \_\_\_\_\_

**Pregnancy Summary**

\*Number of Miscarriages (less than 20 weeks): \_\_\_\_\_ \*Number of Ectopic/Tubal Pregnancies: \_\_\_\_\_

\*Number of Elective Terminations (Abortions): \_\_\_\_\_ \*Total number of ALL Pregnancies: \_\_\_\_\_

\*Number of Full Term Deliveries: \_\_\_\_\_ Of these, how many were live births? \_\_\_\_\_ How many were Stillborn? \_\_\_\_\_

\*Number of Premature (less than 37 weeks) Deliveries? \_\_\_\_\_ Of these, how many were live birth? \_\_\_\_\_ How many were Stillborn? \_\_\_\_\_

\*Any Pregnancies with Birth Defects?  No  Yes \_\_\_\_\_

Date Pregnancy Ended or Delivered	Months to Conception	Treatments to Conceive	Delivery Type/ D&C Complications	Current Partner?
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No
				<input type="radio"/> Yes <input type="radio"/> No

**Menstrual History**

Menstrual cycle pattern (check all that apply):  Regular periods  Irregular periods  No periods  
 Spotting before periods  Heavy periods  Light Periods  Bleeding between periods

Number of days between the start of one period to the start of the next period: \_\_\_\_\_ days

How many days of bleeding do you have? \_\_\_\_\_ days

Dates of the 1st day of your last 2 menstrual periods: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_; \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Age when you had your first period: \_\_\_\_\_ years old.

Age when you first noticed: Breast development: \_\_\_\_\_ Pubic hair: \_\_\_\_\_ Underarm hair: \_\_\_\_\_

How many periods do you have per year? \_\_\_\_\_

Do you need medication to bring on a period?  Yes – what type? \_\_\_\_\_  No

If you do not have periods, at what age did you stop having them? \_\_\_\_\_ years old

Do you have severe cramping or pelvic pain with your periods?  Yes- Always/Sometimes/Recently/In the past  No

**Contraceptive History**

None  Condoms -dates of use \_\_\_\_\_  Diaphragm - dates of use \_\_\_\_\_

IUD - dates of use \_\_\_\_\_  Birth control pills - dates of use \_\_\_\_\_ Complications? \_\_\_\_\_

Never used birth control pills  Injectable contraception - dates of use \_\_\_\_\_ Complications? \_\_\_\_\_

Skin patch - dates of use \_\_\_\_\_ - complications? \_\_\_\_\_  Foam or Jelly?

Tubal sterilization procedure - date \_\_\_\_\_  Tubes untied - date \_\_\_\_\_

Did your mother take DES when she was pregnant with you?  No  Yes

**Sexual History**

How many times do you have intercourse per week? \_\_\_\_\_ times per week  None  N/A

Have you used over-the-counter ovulation kits to time intercourse?  Yes  No

Do you have pain with intercourse?  Yes  No

Do you use lubricants during intercourse?  Yes  No

Have you had any of the following sexually transmitted disease or pelvic infections?  Yes  No

Chlamydia - date \_\_\_\_\_  Gonorrhea - date \_\_\_\_\_  Herpes - date \_\_\_\_\_  Syphilis - \_\_\_\_\_

Genital warts/HPV - date \_\_\_\_\_  HIV/AIDS - date \_\_\_\_\_  Hepatitis - date \_\_\_\_\_  Other - \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Pap Smear History**

- When was your last pap smear (month and year)? \_\_\_\_\_ / \_\_\_\_\_  Normal  Abnormal
- When was your last abnormal pap smear? \_\_\_\_\_  Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?  Yes (check all that apply)  No  
 Colposcopy  Cryosurgery (freezing)  Laser treatment  Conization  LEEP procedure

**Breast Screening History**

Have you ever had a mammogram?  No  Yes – date \_\_\_\_\_ Result:  Normal  Abnormal \_\_\_\_\_  
 Do you perform breast self exams?  Yes  No

**Medical History**

- Are you allergic to any medications?  No  Yes (Please list and describe reactions)  
\_\_\_\_\_
- Are you allergic to any foods?  No  Yes (Please list and describe reactions)  
\_\_\_\_\_  
\_\_\_\_\_
- List any medications you are currently taking, including over-the-counter medicines. \_\_\_\_\_
- Do you take any herbal medicines/vitamins or health food store supplements?  No  Yes  
(Please list) \_\_\_\_\_
- Do you have any medical problem(s)?  No  Yes (Please list type, dates, and treatments.)  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_  
 5. \_\_\_\_\_
- Did you have either of these childhood illnesses?  Chickenpox (Varicella)  German Measles (Rubella)  
 Other childhood diseases: \_\_\_\_\_

**Vaccinations**

- Chickenpox (Varicella):  No  Yes(dates \_\_\_\_\_)  Don't know
- MMR – Measles, Mumps, and Rubella (German Measles):  No  Yes(dates \_\_\_\_\_)  Don't know
- BCG (Tuberculosis):  No  Yes(dates \_\_\_\_\_)  Don't know
- Hepatitis B:  No  Yes(dates \_\_\_\_\_)  Don't know
- Polio:  No  Yes(dates \_\_\_\_\_)  Don't know
- Hepatitis A:  No  Yes(dates \_\_\_\_\_)  Don't know
- Tetanus:  No  Yes(dates \_\_\_\_\_)  Don't know
- Influenza:  No  Yes(dates \_\_\_\_\_)  Don't know

**Social History**

- How many caffeinated beverages (coffee, tea, soda) do you drink per day? \_\_\_\_\_  None
- Do you smoke cigarettes?  No  Yes How many/day? \_\_\_\_\_ How many years? \_\_\_\_\_ Quit?- when \_\_\_\_\_
- Do you drink alcohol?  No  Yes Beer - # per week \_\_\_\_\_ Wine - # per wk \_\_\_\_\_ Liquor - # per wk \_\_\_\_\_
- Do you use marijuana, cocaine, or any other similar drug?  No  Yes (describe \_\_\_\_\_)
- Do you exercise?  No  Yes (describe \_\_\_\_\_)
- Are you aware of any radiation exposures other than X-rays?  No  Yes (describe \_\_\_\_\_)

Patient Name: \_\_\_\_\_

**Surgical History**

- Have you had any surgeries?  No  Yes (List all surgeries in chronologic order.)  
 Year \_\_\_\_\_ Reason and Type of Surgery  
 \_\_\_\_\_ 1. \_\_\_\_\_  
 \_\_\_\_\_ 2. \_\_\_\_\_  
 \_\_\_\_\_ 3. \_\_\_\_\_  
 \_\_\_\_\_ 4. \_\_\_\_\_  
 \_\_\_\_\_ 5. \_\_\_\_\_
- Did you have any anesthesia problems?  No  Yes (describe \_\_\_\_\_)

**Physical Symptoms**

**General**

- Recent weight gain or loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other \_\_\_\_\_
- None

**Head, Eyes, Ears, Nose, and Throat:**

- Dizziness  Loss of sense of smell
- Headaches  Chronic nasal congestion
- Blurred vision  Ringing ears
- Hearing loss/deafness
- Other \_\_\_\_\_
- None

**Respiratory:**

- Shortness of breath
- Pneumonia  Bronchitis
- Asthma  Tuberculosis
- Bloody cough
- Other \_\_\_\_\_
- None

**Endocrine/Hormonal:**

- Diabetes  Hair loss
- Thyroid gland problems
- Rapid weight gain or loss
- Excessive hunger/thirst
- Temperatures intolerance-
- Hot flashes or feeling cold
- Other \_\_\_\_\_
- None

**Breasts:**

- Discharge (clear? \_\_\_\_, bloody? \_\_\_\_, milky? \_\_\_\_)
- Lumps  Pain  Cancer
- Abnormal mammogram
- Reduction
- Augmentation/Breast implants  
(saline? \_\_\_\_, silicone? \_\_\_\_)
- Other \_\_\_\_\_
- None

**Neurological Problems:**

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory loss
- Other \_\_\_\_\_
- None

**Gastrointestinal:**

- Nausea/Vomiting  Ulcers
- Hepatitis  Diarrhea
- Blood in your stool  Constipation
- Irritable Bowel Syndrome
- Change in bowel habits
- Colitis (ulcerative or Crohn's)
- Other \_\_\_\_\_
- None

**Genito-Urinary:**

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination  Leaking urine
- Blood in urine
- Herpes
- Other \_\_\_\_\_
- None

**Skin/Extremities:**

- Unexplained rash
- Acne
- Skin cancer
- Burn injury
- moles changing appearance
- Excess hair growth
- Other \_\_\_\_\_
- None

**Musculoskeletal**

- Unusual muscle weakness
- Decreased energy/stamina
- Rheumatoid arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other \_\_\_\_\_
- None

**Hematologic:**

- Blood clotting disorder/Blood clot
- Sickle cell Anemia  Thrombophlebitis
- Easy bruising
- Swollen glands/lymph nodes
- Blood transfusion (date/reason \_\_\_\_\_)
- Other \_\_\_\_\_
- None

**Cardiovascular:**

- Palpitations
- Chest pain  Stroke
- Heart attack
- Murmur
- High blood pressure
- Rheumatic fever
- Other \_\_\_\_\_
- None

**Mental Health Problems:**

- Depression  Anxiety disorder  Schizophrenia  Other  None

Patient Name: \_\_\_\_\_

**Family History**

	<u>Living/Age</u>	<u>Cause of Death/Age</u>
• Mother	_____	_____
• Father	_____	_____
• Brother	_____	_____
• Sister	_____	_____
• Maternal Grandmother	_____	_____
• Grandfather	_____	_____
• Paternal Grandmother	_____	_____
• Grandfather	_____	_____

**What is your Ancestry?**

- African-America
- American Indian/Native American
- Ashkenazi Jewish
- Asian-American
- Cajun/French Canadian
- Caucasian
- Eastern European
- Hispanic/Caribbean
- Northern European
- Southern European
- Other (specify \_\_\_\_\_)

**Disorders in Your Family**

	<u>Relationship to You</u>		
	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Breast cancer	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Ovarian cancer	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Colon cancer	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Other cancer _____	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Diabetes	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Thyroid problems	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Heart disease	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Blood clots	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Obesity	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Psychiatric problems	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Tuberculosis	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Endometriosis	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Infertility	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Menopause before age 40	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Birth defects	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Cystic Fibrosis	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Tay-Sachs disease	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Canavan disease	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Bloom syndrome	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Gaucher disease	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Niemann-Pick disease	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Fanconi Anemia	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Familial Dysautonia	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Muscular Dystrophy	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Neurologic (brain/spine)	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Neural Tube Defects	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Bone/Skeletal Defects	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Dwarfism	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Developmental delay	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Learning problems	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Polycystic kidney disease	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Heart defect from birth	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Down syndrome	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Other chromosome defects	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Marfan syndrome	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Hemophilia	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Sickle Cell Anemia	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Thalassemia	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Deafness/Blindness	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Color Blindness	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____
• Hemochromatosis	<input type="radio"/> Yes _____	<input type="radio"/> No _____	<input type="radio"/> Don't know _____

**What would you like to be screened for?**

- \_\_\_\_ Cystic Fibrosis
- \_\_\_\_ Sickle Cell Anemia
- \_\_\_\_ Tay-Sachs Disease
- \_\_\_\_ Thalassemia

**Patient Name:**  
\_\_\_\_\_

**PRIOR INFERTILITY TESTING AND TREATMENT**

- Have you had prior infertility testing or treatment elsewhere?  No  Yes

- Prior Tests (check all that apply):  Basal body temperature chart (date \_\_\_\_\_/results \_\_\_\_\_)
- Thyroid test (date/results \_\_\_\_\_)  Ovulation test kit (date/results \_\_\_\_\_)
- Day 3 blood test for FSH level (date/results \_\_\_\_\_)  Hysterosalpingogram (HSG)(date/results \_\_\_\_\_)
- Laparoscopy surgery (date/results \_\_\_\_\_)  Hysteroscopy surgery (date/results \_\_\_\_\_)
- Progesterone blood test(date/results \_\_\_\_\_)  Prolactin blood test(date/results \_\_\_\_\_)

Prior Treatment (check all that apply): # of cycles                      Dates    Outcome

Prior Treatment (check all that apply):	# of cycles	Dates	Outcome
<input type="radio"/> <u>Intrauterine insemination:</u>	_____	From _____ to _____	___ Pregnant: ___ Delivered, ___ Ectopic, ___ Miscarriage ___ Nonpregnant
<input type="radio"/> <u>Clomiphene citrate w/ timed intercourse:</u> Maximum # tablets per day? _____	_____	From _____ to _____	___ Pregnant: ___ Delivered, ___ Ectopic, ___ Miscarriage ___ Nonpregnant
<input type="radio"/> <u>Clomiphene citrate w/ insemination:</u> Maximum # of tablets per day? _____	_____	From _____ to _____	___ Pregnant: ___ Delivered, ___ Ectopic, ___ Miscarriage ___ Nonpregnant
<input type="radio"/> <u>Daily fertility drug inj. w/ insemination</u> Maximum # vials per day? _____	_____	From _____ to _____	___ Pregnant: ___ Delivered, ___ Ectopic, ___ Miscarriage ___ Nonpregnant
<input type="radio"/> <u>Completed in vitro fertilization cycle</u>			
1. # eggs _____ #embryos transferred _____ #frozen _____	_____	From _____ to _____	___ Pregnant                      ___ Non pregnant
2. # eggs _____ #embryos transferred _____ #frozen _____	_____	From _____ to _____	___ Pregnant                      ___ Non pregnant
3. # eggs _____ #embryos transferred _____ #frozen _____	_____	From _____ to _____	___ Pregnant                      ___ Non pregnant
4. # eggs _____ #embryos transferred _____ #frozen _____	_____	From _____ to _____	___ Pregnant                      ___ Non pregnant
<input type="radio"/> <u>Frozen embryo transfers:</u>			
1. # embryos transferred _____	_____	From _____ to _____	___ Pregnant                      ___ Non pregnant
2. # embryos transferred _____	_____	From _____ to _____	___ Pregnant                      ___ Non pregnant
3. # embryos transferred _____	_____	From _____ to _____	___ Pregnant                      ___ Non pregnant
4. # embryos transferred _____	_____	From _____ to _____	___ Pregnant                      ___ Non pregnant
<input type="radio"/> <u>Canceled in vitro fertilization attempt:</u>	_____		

Any other prior treatment (describe): \_\_\_\_\_

- Additional Information/Complications: \_\_\_\_\_

**Emotional Status:**

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures \_\_\_\_\_

Do you see a counselor?  No  Yes - For how long? \_\_\_\_\_ How often? \_\_\_\_\_

List any antidepressant/anti-anxiety medications you are currently taking. \_\_\_\_\_

Describe any emotional, marital, or sexual problems caused by your infertility \_\_\_\_\_

**\*PLEASE BE SURE TO READ AND SIGN A COPY OF OUR OFFICE POLICY STATEMENT\***

My signature authorizes The Institute for Women’s Health Specialists to release any information acquired in the course of my treatment:

PATINT’S SIGNATURE _____	DATE _____
I confirm that I have reviewed the information above.	
PHYSICIANS SIGNATURE _____	DATE _____

Patient Name: \_\_\_\_\_

PART III: MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

- Have you been evaluated by a urologist?       Yes             No
- Have you previously conceived with another woman?  
                                   Yes: How many times? \_\_\_\_       No: Birth control used? Yes \_\_\_\_ No \_\_\_\_
- Have you had a semen analysis?                     Yes             No
- Do you have difficulty with erections?             Yes             No
- Do you have retrograde ejaculation of sperm into the bladder?     Yes             No
- Have you had any of the following sexually transmitted diseases or pelvic infections?  
 Yes (check all that apply)                     No  
 Chlamydia – date \_\_\_\_\_     Gonorrhea – \_\_\_\_\_     Herpes – \_\_\_\_\_                     HIV/AIDS- \_\_\_\_\_  
 Syphilis – \_\_\_\_\_     Genital warts/HPV- \_\_\_\_\_     Hepatitis- \_\_\_\_\_                     Other \_\_\_\_\_
- Have you had a history of undescended testicles?     Yes One side \_\_\_\_ Both \_\_\_\_                     No
- Do you have scrotal or testicular pain?             Yes             No
- Did you have the mumps after puberty?             Yes             No
- Have you had prior injury to your testicles requiring hospitalization?     Yes             No
- Have you been diagnosed with any of the following disease?  
Diabetes Mellitus – Yes \_\_\_\_ No \_\_\_\_                    Cancer – Yes \_\_\_\_ No \_\_\_\_  
Multiple Sclerosis – Yes \_\_\_\_ No \_\_\_\_                    Other neurological problems – Yes \_\_\_\_ No \_\_\_\_  
Prostatic infections – Yes \_\_\_\_ No \_\_\_\_                    Urinary infections – Yes \_\_\_\_ No \_\_\_\_  
High Blood pressure – Yes \_\_\_\_ No \_\_\_\_                    If yes, any medications? \_\_\_\_\_
- Have you had any fever in the last 3 months?       Yes             No
- Have you had a vasectomy? If yes when \_\_\_\_\_     Yes             No  
If yes, have you had a vasectomy reversal?             Yes             No
- Have you had surgery for varicocele repair?             Yes             No
- Have you had hernia surgery?                     Yes             No
- Did you undergo any bladder or penis surgery as a child?     Yes             No
- Are you exposed to prolonged heat in the workplace?       Yes             No
- Are you exposed to any radiation or harmful chemicals in the workplace?     Yes             No
- Have you had chemotherapy for cancer?             Yes             No
- Are you allergic to any medications?             Yes             No  
(Please list and describe reactions) \_\_\_\_\_  
\_\_\_\_\_

List your current medication? \_\_\_\_\_

List any current medical problem(s): \_\_\_\_\_

- How many caffeinated beverages do you drink per day? \_\_\_\_       None
- Do you smoke cigarettes?     No     Yes How many/day? \_\_\_\_ How many years? \_\_\_\_     Quit –when \_\_\_\_\_
- Do you drink alcohol?     No     Yes Beer - # per wk \_\_\_\_ Wine -# per wk \_\_\_\_ Liquor - # per wk \_\_\_\_
- Do you use marijuana, cocaine, or any other similar drug?     No     Yes (describe \_\_\_\_\_)
- Are you aware of any radiation/toxic materials exposure?     No     Yes
- Do you use hot tubs regularly?     No     Yes
- Did your mother take DES during pregnancy to prevent miscarriage?     No     Yes     Don't know
- Have any of your immediate family members had difficulty conceiving a child?       No     Yes  
If yes, please describe \_\_\_\_\_

**Disorders in Your Family**

- |   | <u>Relationship to You</u>                  |       |   |
|---|---|-------|---|
| • Cystic Fibrosis                       | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Tay-Sachs disease                     | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Canavan disease                       | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Bloom syndrome                        | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Gaucher disease                       | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Niemann-Pick disease                  | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Fanconi Anemia                        | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Familial Dysautonia                   | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Muscular Dystrophy                    | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Neurologic (brain/spine)              | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Neural Tube Defects                   | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Bone/Skeletal Defects                 | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Dwarfism                              | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Developmental delay                   | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Learning problems                     | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Polycystic kidney disease             | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Heart defect from birth               | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Down syndrome                         | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Other Chromosome defects              | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Marfan syndrome                       | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Hemophilia                            | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Sickle Cell Anemia                    | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Thalassemia                           | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Galactosemia                          | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Deafness/Blindness                    | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Color Blindness                       | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| • Hemochromatosis                       | <input type="radio"/> Yes                   | _____ | <input type="radio"/> No <input type="radio"/> Don't know |
| <input type="radio"/> None of the above | <input type="radio"/> Other (Specify _____) |       |   |

**What is your Ancestry?**

- African-American
- American Indian
- Native American
- Ashkenazi Jewish
- Asian-American
- Cajun/French Canadian
- Caucasian
- Eastern European
- Hispanic/Caribbean
- Northern European
- Southern European
- Other (specify \_\_\_\_\_)

**Would you like to be screened for?**

- Cystic Fibrosis:
- Sickle Cell Anemia
- Tay-Sachs Disease
- Thalassemia

**SPOUSE/MALE PARTNER'S SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**I confirm that I have reviewed the information above.**

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_