

CELEBRATION OF LIFE SPONSORSHIP PROGRAM
MALE PATIENT HISTORY -- CONFIDENTIAL - FOR OFFICE USE ONLY

Administrative Information

Social Security #: _____ Date: _____
Full Name: _____ Your Age: _____
Address: _____ Date of Birth: _____ Blood Type: _____
Race: _____
Country: _____ Marital Status: M S D W Other: _____
Telephone: (H) _____ (W) _____ (C) _____
Partner's Full Name: _____ DOB: _____ Social Security #: _____

Male Reproductive History

Have you had a vasectomy? _____ What year? _____
Was this reversed? _____ What year? _____

Have you ever been diagnosed with any of the following (Y or N):

| | | | |
|----------------------------|-------|--------------------------|-------|
| Exposure to DES | _____ | Hypospadias | _____ |
| Testicular Cancer | _____ | Chromosome Abnormalities | _____ |
| Testicular Surgery | _____ | AIDS | _____ |
| Exposure to Chemotherapy | _____ | Prostatitis | _____ |
| Exposure to Radiation | _____ | Testes Injury | _____ |
| Exposure to Excessive Heat | _____ | Testes Tumor | _____ |
| Endocrine Disorders | _____ | Testes Infection | _____ |
| Mumps | _____ | Bladder Infection | _____ |
| Venereal Disease | _____ | Gonorrhea | _____ |
| Infection | _____ | Syphilis | _____ |
| Varicocele | _____ | Herpes | _____ |
| Ductal Obstruction | _____ | Mycoplasma | _____ |
| Ejaculatory Disorders | _____ | Chlamydia | _____ |
| Other Disorders | _____ | Explain: _____ | _____ |

Are there any hereditary/genetic illnesses that run in the family? _____

If yes, explain: _____

Has anyone in your family had a child with a congenital abnormality? _____

If yes, explain: _____

Does anyone in your family have a history of infertility? _____

If yes, explain: _____

Have you undergone previous treatment, surgery, or taken medication to improve the quality of your semen? _____

If yes, please describe: _____

Have you previously obtained a pregnancy with another partner? _____

If yes, outcome of pregnancy: _____

Have you ever had a discharge from your penis or a urinary tract infection? _____

If yes, when? _____

Name of personal physician: _____

Medical History -- MALE

Height: _____ Weight: _____ Blood Type: _____

Do you have or have you ever had (check all that apply):

| | | | |
|---------------------------|------------------------|---------------------------|---------------------------|
| Heart Disease _____ | Tuberculosis _____ | Measles (German) _____ | Emotional Disorders _____ |
| Hypertension _____ | Colitis _____ | Measles (Regular) _____ | Blood Transfusion _____ |
| Gallbladder Disease _____ | Diabetes _____ | Neurologic Problems _____ | Hepatitis _____ |
| Liver Disease _____ | Anemia _____ | Ulcers _____ | Arthritis _____ |
| Kidney Disease _____ | Thyroid Problems _____ | Epilepsy _____ | Other _____ |

Have you lost or gained 20 or more pounds in the past year? _____

If yes, explain: _____

Are you taking any medications (over the counter or prescription) on a regular basis? _____

If yes, please list: _____

Allergies to medicine: _____

Current supplements: _____

Current herbal or homeopathic therapies: _____

Hospitalizations:

| | Date | Reason | Surgery | Type Surgery |
|----|-------|--------|--|--------------|
| 1) | _____ | _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 2) | _____ | _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 3) | _____ | _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |

Social History/Habits

Occupation: _____

of years: _____

Are you exposed to any hazards in your job (i.e., chemicals, toxic fumes, radiation?) Yes No

If so, please list: _____

Do you use tobacco? _____ If so, how many cigarettes per week? _____

Do you drink alcohol? _____ If so, how many glasses per week? _____

Do you use recreational drugs such as marijuana or cocaine? _____

If yes, please list: _____

Do you use saunas or hot tubs? _____ How often? _____

Exercise habits: Type: _____ Hours per week? _____

Family History

Do any members of your family have:

| | |
|-----------------------------|----------------|
| High Blood Pressure _____ | Cancer _____ |
| Heart Disease _____ | Diabetes _____ |
| Kidney Disease _____ | Seizures _____ |
| Other Serious Illness _____ | |