

men's fertility history

NAME (LAST, FIRST, MIDDLE)	DATE
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How long have you and your partner been trying to conceive?

How would you best describe your sexual energy?

BELOW NORMAL
 NORMAL
 ABOVE NORMAL
 HIGH

Please check Yes or No beside each question.

	YES	NO
Do you have undescended testes?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with a varicocele?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any urologic surgeries?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a vasectomy reversed?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced difficulty maintaining erection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced difficulty ejaculating?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been exposed to any known environmental toxins or hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Have you experienced any penile discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly experience nocturnal emission?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a fertility workup?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what is your sperm count? <input type="checkbox"/> BELOW NORMAL <input type="checkbox"/> NORMAL NUMBER: _____		
What was the sperm motility? <input type="checkbox"/> BELOW NORMAL <input type="checkbox"/> NORMAL NOTES: _____		
What was the sperm morphology? <input type="checkbox"/> BELOW NORMAL <input type="checkbox"/> NORMAL NOTES: _____		

COMMENTS / NOTES