

Men's Fertility History

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Name: _____

Date: _____

How long have you and your partner been trying to conceive? _____

Please circle your answers for the questions below

How is your sexual energy?	Low	Normal	High
Do you have (or have had) an undescended testicle(s)?	Yes	No	
Have you ever been diagnosed with a varicocele?	Yes	No	
Have you had any urological surgeries?	Yes	No	
Have you had a vasectomy reversed?	Yes	No	
Have you experienced difficulty ejaculating?	Yes	No	
Have you experienced difficulty maintaining an erection?	Yes	No	
Have you been exposed to any known environmental toxins or hormones?	Yes	No	
Do you smoke cigarettes or marijuana?	Yes	No	
Have you experienced any irregular penile discharge?	Yes	No	
Do you regularly experience ejaculation while sleeping?	Yes	No	
Have you had a sperm analysis?	Yes	No	
If yes, what was your sperm count? Below normal or Normal	Number	_____	
What was the sperm motility? Below normal or Normal	Notes	_____	
What was the sperm morphology? Below normal or Normal	Notes	_____	

Please list any prescription medication that you are currently taking:

Please list any non-prescription medication that you are currently taking including herbs, vitamins and over the counter medications: _____
