Male History

Welcome to Advanced Reproductive Center of Hawai'i. Please take a moment to provide the information requested below so our team can better serve you.

Advanced Reproductive Center *of* Hawai'i

PATIENT NAME _____ AGE _____ DATE OF BIRTH _____

Who referred you for In-Vitro Fertilization treatment? _____

Family history

Any history of the following in your immediate family (Mother, Father, Siblings):

Alcoholism _____ Birth Defects _____

Breast Disease _____ Cancer _____

Diabetes (on insulin) _____ Heart Disease _____

High Blood Pressure _____ Infertility/Miscarriage _____

General health history

Please indicate if you have ever experienced any of the following:

- ☐ Headaches ☐ Asthma ☐ Heart Problems ☐ Depression ☐ High Blood Pressure
- ☐ Cancer ☐ Diabetes ☐ Liver Problems ☐ Anxiety ☐ Thyroid Problems
- ☐ Drug Abuse ☐ Kidney Problems ☐ Abnormal Hair Growth
- ☐ Other *(Please specify)* _____
- ☐ Any known drug allergies _____

Current medications that you are taking _____

Have you ever had a blood transfusion? If so, when? _____ ☐ NO ☐ YES

Surgical history

Please list all surgical procedures that you have had:

	DATE	TYPE OF SURGERY	PHYSICIAN	FINDINGS (IF ANY)
1				
2				
3				

Kapi'olani Medical Center for Women & Children
1319 Punahou Street, Suite 510, Honolulu, Hawai'i 96826
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Male History *(continued)*

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Reproductive history

Have you ever fathered any children? If yes, when? _____ ☐ NO ☐ YES

Do you have difficulty with erection and/or ejaculation? ☐ NO ☐ YES

Have you ever had a vasectomy? ☐ NO ☐ YES

Have you ever had a semen analysis? If yes, when? _____ ☐ NO ☐ YES

Results _____

Are there any birth defects in your family? If yes, type of defect? _____ ☐ NO ☐ YES

Social history

Do You smoke? If yes, how much per day? _____ ☐ NO ☐ YES

Do you drink alcohol? If yes, how often? _____ ☐ NO ☐ YES

Do you use illicit drugs? If yes, what and how often? _____ ☐ NO ☐ YES

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