

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:

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

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