Men's Health History **CONFIDENTIAL**

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NAME (LAST, FIRST, MIDDLE)	DATE

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

How is your sexual energy? Low Normal High

Do you have undescended testes? Yes No

Have you ever been diagnosed with a varicocele? Yes No

Have you had any urologic surgeries? Yes No

Have you had a vasectomy reversed? Yes No

Have you experienced difficulty maintaining an erection? Yes No

Have you experienced difficulty ejaculating? Yes No

Have you been exposed to any known environmental toxins or hormones? Yes No

Do you smoke? Yes No

Do you eat soy products? Yes No

Do you eat lots of processed snack foods? Yes No

Have you experienced penile discharge? Yes No

Do you regularly experience nocturnal emissions? Yes No

Have you had a fertility workup? Yes No

If yes, what was your sperm count? Below normal Normal Number____________________

What was the sperm motility? Below normal Normal Specifics____________________

What was your sperm morphology? Below normal Normal Specifics____________________

Are you taking any prescription medications? Yes No

If so, what are they?

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Please list any non-prescription medications you are currently taking, including herbs, supplements, and over-the-counter medications:

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Notes: