

Height _____ Weight _____

Have you had any tests to see why your partner is not getting pregnant? Yes / No

If Yes, please explain _____

Have you, yourself, had any treatments for infertility? Yes / No

If Yes, please describe: _____

Do you have or have you ever suffered from any of the following:

Disease / Symptom	No	Yes	Explain
Diabetes			
Inflammation of one or both testicles			Left / Right / or Both
Lung Disease			
Disease of the brain or nervous system			
Pain passing urine			
Blood in the urine or semen			
Difficulty passing urine			
Any other problems related to passing urine			

Any other illness, surgery, or other treatment of which you think we should be aware?

Please explain: _____

Were you ever told that one or both of your testicles was not fully down at birth? Yes / No

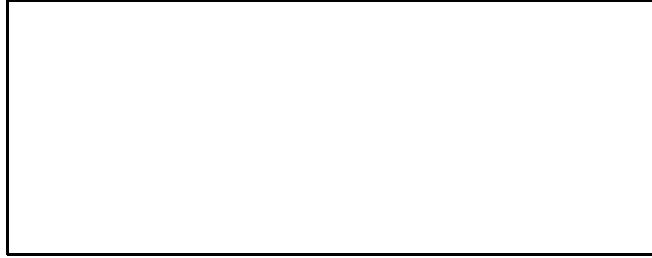
If Yes, was it: Left / Right / or Both

Was this treated surgically? Yes / No If Yes, at what age? _____ years

Have you ever had any surgery to the penis, scrotum, or testicles? Yes / No

If Yes, please describe _____

Have you ever had a hernia surgery? Yes / No If Yes, when? _____



Do you have any problems with erection, penetration, or orgasm? Yes / No

If Yes, please describe: _____

Have you ever had any sexually transmitted (venereal) disease? Yes / No

If Yes, how many episodes: _____

when was the most recent episode? _____

was it treated? _____

How often do you have intercourse per week? _____

Have you ever had an infection which was not treated? Yes / No

Describe your most recent infection (eg. Gonorrhea, syphilis, etc.): _____

The following questions are to discover whether there is anything to which you are exposed which might affect your fertility:

Do you smoke? Yes / No If Yes, how many per day _____ or per week _____

Do you drink alcohol? Yes / No If Yes, how many drinks per week _____

Have you ever taken anabolic steroids? Yes / No

Are you on any medications? Yes / No If Yes, please indicate which drug(s) and the frequency with which you take it/them: _____

Do you smoke marijuana? Yes / No If Yes, how often: _____

Do you use any other "street drugs"? Yes / No

Do you use a hot tub or sauna regularly? Yes / No If Yes, how often: _____

Have you had a vasectomy? Yes / No If Yes, when: _____

Have you had a vasectomy reversal? Yes / No If Yes, when: _____

Please use the remainder of this page to add any further information which you think may help us with your problem.

Information completed by: _____ Date: _____

(Signature)