Ontario Network of Experts in Fertility
life through knowledge

Affiliated with McMaster University

ONE FERTILITY KITCHENER WATERLOO
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P 519-650-0011 **F** 519-650-0033
www.onefertilitykw.com

SECTION ONE: MALE PARTNER HISTORY

Name:	Date:
Age:	Ethnic Origin:
Occupation:	Primary Contact Number:
Email Address:	

1) Have you previously had a semen analysis completed? Yes □ No □

If you answered yes:

a) When was it complete? _____

b) Where was it done? _____

c) What was the result? _____

2) Any children or pregnancies in a previous relationship? Yes □ No □

a) What was the pregnancy outcome (I.E. healthy child?) _____

3) Do you have any history of injuries to the penis or scrotum? Yes □ No □

If yes, please specify:

_____

_____

4) Do you have any history of any of the following:

Prostate infection Yes □ No □ Herpes Yes □ No □

Gonorrhea Yes □ No □ Genital warts Yes □ No □

Chlamydia Yes □ No □

5) Do you have a history of an undescended testicle as a baby? Yes □ No □

a) If yes, was it corrected with surgery? Yes □ No □

If yes, how old were you when it was corrected? _____

6) Have you had surgery for any of the following?

a) Hernia repair? Yes □ No □

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b) Varicocele? Yes □ No □

c) Have you had a vasectomy? Yes □ No □

If you answered yes to any of the above, please specify:

Date of Procedure: _____ Physician / Surgeon: _____

d) Have you had a vasectomy reversal? Yes □ No □

If yes, please specify the date and Physician / Surgeon: _____

e) Please list any other surgeries you've had previously:

_____

_____

7) Are you under a doctor's care for past or ongoing medical concerns? Yes □ No □

If yes, please specify:

_____

_____

8) Do you take any prescription medications regularly? Yes □ No □

If yes, please specify:

_____

_____

9) Do you use any over the counter medications or complementary and alternative medications?

Yes □ No □

If yes, please specify:

_____

_____

10) Do you have an allergy to latex? Yes □ No □

11) Do you have any other allergies to either medications or environmental? Yes □ No □

If yes, please specify:

_____

_____

12) Do you drink alcohol: Yes □ No □

If yes, how many beverages do you drink per week? _____

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13) Do you currently smoke? Yes □ No □

If yes, how many cigarettes/packs per day? _____

Have you ever smoked? Yes □ No □

If yes, when did you quit? _____

14) Are you exposed to any chemicals in your home or workplace? Yes □ No □

If yes, please specify: _____

15) Are you exposed to excessive heat to the testicles (ex. hot tub, work related?) Yes □ No □

If yes, please specify: _____

16) Have you been vaccinated for Hepatitis B in the past? Yes □ No □

If yes, please specify: _____

SECTION TWO: FAMILY HISTORY

1) Is there a family history of any of the following?

	Yes	No	Family Member	Please Provide Details
Stillbirths				
Neural Tube Defects				
Intellectual Disability				
Childhood Death				
Recurrent Pregnancy Loss				
Genetic (chromosome) Abnormalities				
Any others-please specify				