

**Fertility History**  
*(Men with fertility problems only)*

Name: \_\_\_\_\_

Year married: \_\_\_\_\_

How long have you and your wife been trying to conceive a child? \_\_\_\_\_

Any previous marriages? Yes No

Any pregnancies in this or previous marriages? Yes No

If so, ages of children: \_\_\_\_\_

Has your wife been married before? Yes No

If so, any pregnancies? Yes No

Methods of contraception - circle those that have been used:

Rhythm      Condom      IUD      Diaphragm      Pills      Other

Have you ever worked around x-ray equipment? Yes No

Have you ever worked in excess heat? Yes No

Do you smoke tobacco? Yes No

Do you smoke marijuana? Yes No

Have you had any recent episode of fever? Yes No

Have you had any problems with testicles descending into the scrotal sac? Yes No

If so, was surgery required? Yes No

Do you take steam baths, saunas or hot tubs? Yes No

Did you ever have the mumps? Yes No

If so, at what age? \_\_\_\_\_

Have you had any infections in or near the testicles? Yes No

Have you had a previous evaluation for fertility problems? Yes No

If so, when? \_\_\_\_\_

What did it show? \_\_\_\_\_

What treatment did you receive? \_\_\_\_\_

How often do you have intercourse? \_\_\_\_\_ Times per week

Do you have multiple ejaculations or orgasms? Yes No