Acupuncture Wellness
&
Fertility Clinic

MEN'S FERTILITY HISTORY

CONFIDENTIAL

415 E. Golf Rd Suite 119 • Arlington Heights, IL 60005 • 847|957-7877

Name:	Date:

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

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you have an 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 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

Have you experienced any penile discharge? ☐ Yes ☐ No

Do you regularly experience nocturnal emission? ☐ 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 Notes _____

What was the sperm morphology? ☐ Below normal ☐ Normal Notes _____

Please list any prescription medications you are currently taking: _____

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

Notes: _____