Updated 9/19/2022

New England Reproductive Medicine and Surgery LLC

Male Intake Form

Name: _____ **Date of birth:** _____

Address: _____

Phone: (H) _____ **(C)** _____

Email: _____

Primary Care Provider: _____ **Urologist:** _____

Preferred Pharmacy: _____ **Address:** _____

Insurance: _____ **Member ID#:** _____

Partner's Name: _____

Medications/supplements: List Name(s) and Dosage below (attach additional sheet if necessary)

_____

_____

Allergies: List Name(s) and Reactions below (attach additional sheet if necessary)

_____

_____

Social History: (select one) ____ Married ____ Partner ____ Single ____ Divorced
Are you safe? ____ Yes ____ No
Who do you live with?

_____

What do you do for exercise?

_____

What do you do for work?

_____

What tobacco/nicotine products do you use?

_____

Did you use tobacco/nicotine products in the past? ____ Yes; When? _____ ____ No
Do you drink alcohol? ____ Yes; How often? _____ ____ No
What other drugs do you use?

_____

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Mental health history:
Do you/did you experience anxiety?
____ Yes; What treatments? _____ ____
No
Do you/did you experience depression?
____ Yes; What treatments? _____ ____
No
Do you/did you experience mood issues?
____ Yes; What treatments? _____ ____
No
Were you hospitalized for anxiety, depression and/or mood issues? ____ Yes ____ No

Family history:
Mom Alive? ____ Yes ____ No; Age at death: _____
Mom's Medical history:
_____

Dad Alive? ____ Yes ____ No; Age at death: _____
Dad's Medical history:
_____

Mother's Mother Alive? ____ Yes ____ No; Age at death: _____
Mother's Mother's Medical history:
_____

Mother's Father Alive? ____ Yes ____ No; Age at death: _____
Mother's Father's Medical history:
_____

Father's Mother Alive? ____ Yes ____ No; Age at death: _____
Father's Mother's Medical history:
_____

Father's Father Alive?____ Yes ____ No; Age at death: _____
Father's Father's Medical history:
_____

Sister(s) Alive? ____ Yes ____ No; Age at death: _____
Sister(s) Medical history:
_____

Brother(s) Alive? ____ Yes ____ No; Age at death: _____
Brother(s) Medical history:
_____

Daughter(s) Alive? ____ Yes ____ No; Age at death: _____

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Daughter(s) Medical history:

_____

Son(s) Alive? ____ Yes ____ No; Age at death: _____
Son(s) Medical history?

_____

Surgical history: attach additional sheet if necessary

_____
_____
_____
_____
_____
_____

Medical problems: attach additional sheet if necessary

_____
_____
_____
_____
_____
_____

Urological history:
Have you had a semen analysis? ____ No ____Yes, date:
_____
Have you been evaluated by a urologist? ____ No ____ Yes
Do you have retrograde ejaculation? ____ No ____ Yes
Have you ever had torsion/twisting of the testicles? ____ No ____ Yes
Have you had undescended testicles? ____ No ____Yes: ____ One side or____ Both sides
Have you had injury to your testicles? ____ No ____Yes, date:
_____
Have you had a vasectomy? ____ No ____ Yes, date:
_____
Have you had a vasectomy reversal? ____ No ____ Yes, date:
_____
Have you had a varicocele? ____ No ____ Yes
Have you had a hernia? ____ No ____ Yes
Have you had fever (>101° F) in the past 3 months? ____ No ____Yes
Did you have mumps after puberty? ____ No ____ Yes
Do you use hot tubs regularly? ____ No ____ Yes
Are you exposed to prolonged heat at work?____ No ____ Yes
Are you exposed to harmful chemicals or fumes at work? ____ No ____ Yes
Have any of your immediate family members had difficulty conceiving a child? ____ No ____ Yes