OBSTETRICS,
GYNAECOLOGY
& FERTILITY

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# MALE HISTORY FORM

Surname: ……..First name:…… dob:…….

Occupation:…… Do you work with chemicals? Yes ( ) No ( )

If yes, please supply details:……

**MEDICAL HISTORY**

Do you suffer from any known medical problems? Yes ( ) No ( )

If yes, please supply details:……..

Have you had the Mumps? Yes ( ) No ( ) If yes, at what age……

Have you ever had any operations? (specifically related to testes, penis or a hernia) Yes ( ) No ( )
If yes, please supply details:……

Do you have any problems with erection, intercourse or ejaculation? Yes ( ) No ( )
If yes, please specify……

Have you fathered any pregnancy? (including miscarriage, termination & live birth) Yes ( ) No ( )

Any known genetic disorders in yourself or other family members? Yes ( ) No ( )
If yes, please outline:……

Any known fertility difficulties in other family members? Yes ( ) No ( )
If yes, please specify if known……

Smoker? Yes ( ) No ( ) If yes, quantity per day……

Average daily alcohol intake:……

Dated:……