PALM BEACH FERTILITY CENTER
MARK DENKER, M.D.

Male Patient Medical History

Today's Date _____

Date of Birth _____ Last Name _____ First Name _____

Age _____ Weight _____ Height _____ Blood Type _____

Occupation _____

Surgery History

List all surgical procedures:

Date	Type of Surgery	Date	Type of Surgery
_____	_____	_____	_____
_____	_____	_____	_____

Medication History

List all medications that you are currently taking:

Medication _____

Medication _____

Medication _____

Medication _____

Allergies

List all allergies (medication, food...)

Allergy _____

Allergy _____

Allergy _____

Allergy _____

Past Medical History

Please choose yes or no to each of the following:

Have you ever been exposed to any of the following?

Extreme heat? ☐ Yes ☐ No Chemicals? ☐ Yes ☐ No Toxic fumes? ☐ Yes ☐ No

Other? ☐ Yes ☐ No Please explain: _____

Do you frequently take saunas or steam baths? ☐ Yes ☐ No

Have you ever had X-rays in the pelvic area? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If Yes, how many drinks per week? _____

Do you smoke? ☐ Yes ☐ No If Yes, how many packs/cigs per day? _____

Do you take recreational drugs? ☐ Yes ☐ No

Have you ever produced a child with another partner? ☐ Yes ☐ No If Yes, how many and ages _____

Do you have trouble with ejaculations? ☐ Yes ☐ No Premature? ☐ Yes ☐ No Retrograde? ☐ Yes ☐ No

Do you have difficulty maintaining an erection? ☐ Yes ☐ No

Do you have a history of Cancer? ☐ Yes ☐ No If Yes, what kind of cancer did you have? _____

Do you have a history of any of the following:

Anemia? ☐ Yes ☐ No

Appendicitis? ☐ Yes ☐ No

Arthritis? ☐ Yes ☐ No

Blood transfusions? ☐ Yes ☐ No

Chlamydia? ☐ Yes ☐ No

Crohn's disease? ☐ Yes ☐ No

Chronic headaches? ☐ Yes ☐ No

Cystic fibrosis? ☐ Yes ☐ No

Diabetes? ☐ Yes ☐ No

Depression? ☐ Yes ☐ No

Gonorrhea? ☐ Yes ☐ No

Heart disease? ☐ Yes ☐ No

Herpes? ☐ Yes ☐ No

High blood pressure? ☐ Yes ☐ No

Kidney disease? ☐ Yes ☐ No

Liver disease? ☐ Yes ☐ No

Measles/mumps? ☐ Yes ☐ No

Mononucleosis? ☐ Yes ☐ No

Prostatis? ☐ Yes ☐ No

Seizures? ☐ Yes ☐ No

Testicular injury? ☐ Yes ☐ No

Testicular tumor? ☐ Yes ☐ No

Thyroid disease? ☐ Yes ☐ No

Uclers? ☐ Yes ☐ No

Varicocele repair? ☐ Yes ☐ No

Vasectomy reversal? ☐ Yes ☐ No

Which of the following tests have you had?

Semen analysis? ☐ Yes ☐ No Date?_____ Results?_____

Chlamydia/GC culture? ☐ Yes ☐ No Date?_____ Results?_____

Sperm Antibody Test? ☐ Yes ☐ No Date?_____ Results?_____

Chromosomal Test? ☐ Yes ☐ No Date?_____ Results?_____

Hormonal Tests? ☐ Yes ☐ No Date?_____ Results?_____

Testicular Biopsy? ☐ Yes ☐ No Date?_____ Results?_____