Men's Health History CONFIDENTIAL

San Diego Fertility Acupuncture
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NAME (LAST, FIRST, MIDDLE)	DATE

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

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

Do you have 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 an 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

Do you eat soy products? ☐ Yes ☐ No

Do you eat lots of processed snack foods? ☐ Yes ☐ No

Have you experienced penile discharge? ☐ Yes ☐ No

Do you regularly experience nocturnal emissions? ☐ 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 Specifics_____

What was your sperm morphology? ☐ Below normal ☐ Normal Specifics_____

Are you taking any prescription medications? ☐ Yes ☐ No

If so, what are they?

_____

_____

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

_____

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Notes: