

Date ____ / ____ / ____		First Name		Last Name			Middle Initial	
Gender <b>M</b> <b>F</b>	Date of Birth ____ / ____ / ____	Age	Marital Status	Height	Weight	Stress level	Occupation	

Name of your RE & I clinic/ Fertility Specialist:

Other OBGYN doctor \_\_\_\_\_

Start Date: \_\_\_\_\_ Month/ Year

Western Diagnosis \_\_\_\_\_

**1. Results for Sperm Analysis:**

Date	Count	Morphology	Motility	Volume

**2. Do we have a copy of your Semen Analysis?**

**Y / N**

**3. Other Procedures/ Date:**

Varicocele	Vasectomy	Vasectomy Reversal	SCSA / ASA	Others

**4. Do you take any of these Supplements and/or Vitamins?**

# of Months on Vitamins	Multi-Vitamin	Herbs	Fish Oil	L - Carnatine	L - Arganine	Antioxidants	CO-Q 10

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**5. Couples ART Plans:**

IUI	Clomid	IVF	PGD	TESA	Other

**6. Has the patient father children Y / N**

**If so, how many \_\_\_\_\_**

**7. Male Health**

Infection	Chlamydia,	Erectile Dysfunction	Ejaculation Problems	Retrograde Ejaculation	Prostate
	Y / N	Y / N	Y / N	Y / N	Y / N

**8. Male Health Continued**

Antisperm Antibodies	Sperm Chromatid / DNA Integrity	High Cholesterol	Diabetes (fasting, glucose)	Others
Y / N	Y / N	Y / N	Y / N	

**9. Is your Partner currently being treated by us?**

**Y / N**

**10.** Partner's Name \_\_\_\_\_

**11.** Western Diagnosis of Spouse \_\_\_\_\_