

Date ____/____/____		First Name		Last Name			Middle Initial	
Gender M F	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

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

Y / N

10. Partner's Name _____

11. Western Diagnosis of Spouse _____