Stony Brook Medicine

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MALE REPRODUCTION ADMISSION RECORD

Please fill out the following form as honestly and completely as you can. The purpose of this information is to help assess your reproductive potential. All information will be held in strict confidence. (Please bring this form with you on your first visit if you received this by mail.)

Patient Profile

1. Name____

2. Address____

____

3. Birthdate______________________**4.** Age ______________________

5. Today's Date____

6. Phone (home)____
(work)____
(cel)____
(e-mail)____

7. Referred by____

8. Marital Status____

Fertility History

1. For how many months have you been trying to achieve pregnancy with your current partner?______________

2. How old is she?______________

3. Have you achieved pregnancy with your current partner in the past?______________

4. If yes, give date and outcome of pregnancies ______________Normal delivery ______________Stillbirth
______________Spontaneous abortion ______________Birth defects
______________Induced abortion ______________Premature Birth
______________Ectopic Pregnancy ______________Caesarean

Section

5. For how many months have you used any of the following contraception methods?______________
______________Condom ______Diaphragm______Foam
____IUD________Pills ______________Rhythm

6. Have you ever undergone sterilization?______________

7. Has your partner ever undergone sterilization?______________

8. Have you been examined for infertility problems elsewhere?______________

9. Have you received treatment for infertility problems elsewhere?______________

10. Has your partner been examined for fertility problems?______________

11. Have you made any previous partner pregnant?______________

12. What was the outcome of those pregnancies______________Normal delivery ______________Stillbirth?
______________Spontaneous abortion ______________Birth defects
______________Induced abortion ______________Premature Birth
______________Ectopic Pregnancy ______________Caesarean

Section

13. Has your partner had any pregnancies with someone other than you in the past?______________

14. What was the outcome of those pregnancies?______________Normal delivery ______________Stillbirth
______________Spontaneous abortion ______________Birth defects
______________Induced abortion ______________Premature Birth
______________Ectopic Pregnancy

Patient ____
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Sexual History

1. Rate your level of sexual desire ________High _______________Moderate _________Slight _________None
2. How many times each week do you have sexual intercourse?______________
3. Do you experience ejaculation during sexual intercourse?_________________
4. Do you ejaculate into your partner's vagina?_____________________
5. Does semen leak out of your partner's vagina after intercourse?____________
6. How often do you ejaculate, weekly?___________________
7. How often do you masturbate, weekly?_________________
8. Do you obtain an erection easily?_______________
9. Do you often have erections in the morning?_____________
10. Are you aware of erections in the morning?____________________________
11. Do you maintain your erections sufficiently for intercourse?_______________
12. Have you ever ejaculated through a flaccid (soft) penis?_________________
13. Do you ever ejaculate prior to penetration for intercourse (premature ejaculation)?__________________
14. About how long does intercourse last before you ejaculate?_______
15. Is intercourse ever painful for your partner?_____________
17. Is her vagina ever so tight that you can't penetrate?___________
18. Does she usually reach orgasm?_______________
19. If yes, through intercourse?___________________
20. Or through other sexual activity?_______________
21. Does her response in any way affect your sexual performance?____________
22. Do you use any form of lubrication for intercourse?______________________
23. Do you ever ejaculate into your partner's rectum?_______________________
24. Does your partner ever swallow your semen?__________________________
25. Is your partner subject to vaginal infections?____________________________
26. Does your partner douche immediately after intercourse?_________________
27. Rate your partner's sexual desire:______High__________Moderate _____________Slight__________None
28. Are your partner's menstrual periods regular?______________
29. Has your partner ever had any of the following illnesses?_____Herpes ______Pelvic inflammatory disease
_____Venereal disease _______Gonorrhea
____________Non-specific urethritis ___________Syphilis
30. Has your partner had abdominal surgery?_________________
31. Do you have intercourse every other day during ovulation?_______________________________________
32. Does your partner usually get out of bed immediately following intercourse?_____________________
33. Do you have a satisfactory marital adjustment?____

General Medical History

1. Have you ever had any of the following illnesses? ________Allergies
_______Arthritis _________________ Bowel disorders
_______Cancer__________________
_______Change in body appearance______________
_______Change in Facial appearance__________
_______Color blindness ___________Deafness __________Diabetes
_______Heart problems ___________Hepatitis
_______Liver disease _____________Lung/breathing problem

Patient____
Pag. 3

Urological History

1. Have you ever had any of the following: _________infection of the prostate ________________of the epididymis
_______of the testicles _______________________ kidney/bladder stones
_______a venereal infection _____non-specific urethritis
_______gonorrhea _____syphilis __________herpes
2. Have you ever had a white, green, yellow discharge from the end of the penis?_______
3. Have you ever had a urinary tract infection?___________________________
4. Have you had a fever in the past 3 months?___________________________
5. Have you ever had blood in your semen?_____________________________
6. Have you ever had pain in your scrotum/testicles?______________________
7. Were both testicles descended at birth?______________________________
8. Have you ever had any injury to your testicles or penis?__________________
9. Have you ever had mumps?____________________
10. If yes, did it affect your testicles?________________
11. Have you ever had an operation for:__________Hernia________Varicocele ___________Hydrocele _______Undes. Testes
__________Abdominal surgery _______Testicular surgery
_____________Vasectomy _____Circumcision_____________Penial surgery
_____________Other surgeries

Endrocrine History

1 .Do you have or ever had:_____Difficulty smelling ___________Headaches______Visual problems
___________Enlarging hands and feet_________Perspiration/sweating problems
___________Changing skin color _____Frequent episodes of lightheadedness/dizzy
___________Growth problems
2. Do you have a general sense of well-being?___________________
3. Do you notice a recent change in your energy level?______________
4. Do you have mood swings?__________________
5. At what age did you first notice: _____Armpit hair _______Pubic hair_______
6. At what age where you when you first shaved?__________
7. How often do you have to shave?_______Twice a day ____Every two days ________Once a day___________Twice a week
______Any changes
8. How does your beard compare to, the men in your family:_________Same ________________Sparser _Heavier

Occupational History

1. What is your present occupation?____
2. Past occupations____
3. Is your occupation stressful?____
4. Do you need to meet rigid deadlines or time schedules?___________________________
5. Do you frequently travel?____
6. Do you fall asleep easily?____
7. Do you wake up early?____
8. Have you been exposed to any of the following:___Prolonged heat______Radiation ___Pesticides
____Agent Orange____Industrial solvents _______Dyes
____Heavy metals ____Plastics
9. Are you taking or have taken any of the following medications:_____Allopurinol ____Antidepressants
____Antihistamine_____Antihypertensive drugs
____Antiparasite agents ____Antipsychotic agents
___Aspirin _Barbiturates ________Chemotherapy
____Cholestyramine____Clofibrate____Digitalis
____Dilantin -Diuretics _______Hormones(estrogen, testosterone, thyroid, etc.)
____Immunosuppressants____Insulin____Nicotinic acid
____Norpace _Penicillin _____Streptomycin _______Sulfa drug
___Tagament_____Tetracycline_____Tranquilizers
_____Other, please explain:__________________________

PATIENT____
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Social History

1. Do you smoke?____

2. How many cigarettes do you have each day?____________________________________

3. Do you smoke marijuana? How much each day?_________________________________

4. Do you consume alcohol? How much each day?_________________________________

5. How many cups of coffee or caffeine-containing sodas do you drink each day?_______________

6. Do you use any of the following subs6ces:________Cocaine_____LSD _______Amphetamines

___________Quaalude___Angel dust _____Heroin______Methadone

7. Do you take long hot baths/sauna?___________

8. Do you use laptop computer in a laptop position?___________ How many years? ________ How many hours a day/week?_______________

Family History

I . Was your mother ever given diethylstilbestrol (DES)?__________________________

2. How many sisters do you have?________________

3. Give the number of children of each of your sisters:_ __Sister(#l) _________Sister(#2) _________Sister(#3)

____Sister(#4)

4. How many brothers do you have?____

5. Give the number of children of each of your brothers: ____Brother(#1) ______Brother(#2)

____Brother(#3) ________Brother(#4)

6. Does anyone in your family have any of the following diseases or conditions?: Birth defects

____Bowel disorder -Cancer ___Cystic disease

____Diabetes - Extra fingers/toes

____Heart disease ___High blood pressure

____Hormone problems_______Kidney disease

____Lung disease_____Poor sense of smell

____Tuberculosis_____Ulcers

Patient____

Physical Exam
FOR PHYSICIANS USE

1. Date:____
2. Height__________Weight__________BP__________Pulse__________Respirations____________________
3. Span in cm__________Symphysis to floor in cm__________Symphysis to crown in cm____________________
4. General appearance (NL)______________________________
5. Skin____
6. Funoscopy______________________________________
7. Eyes close together________________________________
8. Head & Neck____________________________________
9. Face____
10.Palate______________________________________
1 1.Back & Spine__________________________________
12.Thyroid______________________________________
13.Heart______________________________________
14.Lungs______________________________________
15.Abdomen____________________________________
16.Extremities__________________________________
17.Short 4th metacarpal______________________________
18.Short 4th metatarsal______________________________
19.Do knees touch when ankles are together?____________________
20.Neurological exam________________________________
21.Hair dist.________temporal________facial ______pubic______auxiliary________chest____________________
22. Fat dist.______________________________________
23.Gynecomastia__________________________________
24.Nipples widely spaced______________________________
25.Musculoskeletal________________________________
26.Escutcheon__________penis __________length __________-foreskin____________________
27.Scrotum______________________________________
28.Testis volume____________RT.__________LT.____________________
29.Testis consistency____________RT.__________LT.____________________
30.Epididymis__________RT.__________LT.____________________
31.Vas deferens__________RT.__________LT.____________________
32-Varicocele__________RT __________LT.____________________
33.Prostate____________Symmetry____________Consistence____________________
Tenderness____________Modules__________Mass____________________
34.Seminal vesicles________________________________
35. Inclusion in protocol:______________________________
36. History of present illness______________________________

DIAGNOSIS:______________________________________

PLAN:______________________________________

CONCLUSION:______________________________________