Dr. Jenkins Patient History Form - Fertility

Sexual Orientation: Heterosexual Gay Bisexual Undefined
Marital status: Single Partnered Married Divorced Widowed
If divorced/widowed, for how long? _____
If in a relationship, how long have you been together? _____
Partner's first name: _____Partner's age: _____
Describe the quality of your relationship: _____

Occupational History
What is your present occupation? _____
Past occupations: _____
Is your occupation stressful? Yes No
Do you need to meet rigid deadlines or time schedules? Yes No
How many hours do you work per week? _____
Do you frequently travel? Yes No
Do you fall asleep easily? Yes No
Do you wake up early? Yes No
In your work or elsewhere, are you or have you ever been exposed to any of the following?
a. Prolonged heat Yes No
b. Radiation Yes No
c. Pesticides Yes No
d. Industrial solvents Yes No
e. Agent Orange Yes No
f. Dyes Yes No
g. Heavy metals Yes No
h. Plastics Yes No

Medication and Drugs
Are you taking, or have you ever taken, any of the following medications:

Allopurinol	Currently	Previously	Never
Anabolic steroids	Currently	Previously	Never
Antidepressants	Currently	Previously	Never
If yes, please specify: _____			
Antihistamines	Currently	Previously	Never
Antiparasite agents	Currently	Previously	Never
Antipsychotic agents	Currently	Previously	Never
Aspirin	Currently	Previously	Never
Barbiturates	Currently	Previously	Never
Blood pressure drugs	Currently	Previously	Never
Chemotherapy	Currently	Previously	Never
Cholestyramine	Currently	Previously	Never
Clofibrate	Currently	Previously	Never
Digitalis	Currently	Previously	Never
Dilantin	Currently	Previously	Never
Diuretics	Currently	Previously	Never
Hormones	Currently	Previously	Never
If yes, please specify: _____			
Immunosuppressants	Currently	Previously	Never
Insulin	Currently	Previously	Never

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Nicotinic Acid	Currently	Previously	Never
Norpace	Currently	Previously	Never
Penicillin	Currently	Previously	Never
Streptomycin	Currently	Previously	Never
Sulfa drugs	Currently	Previously	Never
Tagamet (Cimetadine)	Currently	Previously	Never
Testosterone/HCG	Currently	Previously	Never
Tetracycline	Currently	Previously	Never
Tranquilizers	Currently	Previously	Never
Propecia or Proscar or Finasteride	Currently	Previously	Never
Alternative Medicines	Currently	Previously	Never

Do you take any blood thinners? Yes No

If so, which one(s)? Aspirin __ Coumadin __ Plavix __ Pradaxa __ Xarelto __ Eliquis ___

Do you take any medications that fall into the category of nitrates? Yes No

Do you carry nitroglycerin with you in case of emergencies? Yes No

Do you use a skin patch for the delivery of medications? Yes No

Social History

Tobacco Use:

Do you or did you ever smoke? Yes No

If yes: How much do you use?

A. Cigarettes _____/Day

B. Cigars /Day_____/Day

C. E-cig (nicotine-based) _____/Day

For how many years? _____

If you stopped, how long ago? _____

Do you use smokeless tobacco? Yes No

For how many years? _____

If you stopped, how long ago? _____

Do you use marijuana? Yes No

If yes, how often do you use marijuana? _____/Week

For how many years? _____

If you stopped, how long ago? _____

Do you drink alcohol containing drinks? Yes No

If yes, how much do you drink? _____/Week

For how many years? _____

If you stopped, how long ago? _____

Do you drink caffeine containing drinks? Yes No

How much? _____/Day

Do you take long baths, saunas, Jacuzzis or steam on a regular basis? Yes No

Can you go up two flights of stairs without chest pain? Yes No

Family History

How many brothers do you have? _____

Do any have fertility problems? _____

How many sisters do you have? _____

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Do any have fertility problems? _____

Are any of the following diseases or conditions present in your family? Who?

a. Birth defects Yes No_____
b. Cancer Yes No_____
c. Cystic fibrosis Yes No_____
d. Diabetes Yes No_____
e. Heart disease Yes No_____
f. High blood pressure Yes No_____
g. Hormone problems Yes No_____
h. Kidney disease Yes No_____
i. Lung disease Yes No_____
j. Poor sense of smell Yes No_____
k. Tuberculosis Yes No_____
l. Genetic abnormalities Yes No_____
m. Varicocele Yes No_____

Fertility History

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

Have you achieved pregnancy with your current partner in the past? Yes No

If yes, give the date and outcome of pregnancies (i.e. spontaneous abortion, induced abortion, caesarean section, still birth, ectopic pregnancy, premature birth, normal delivery)

Date Outcome

Pregnancy #1 _____
Pregnancy #2 _____
Pregnancy #3 _____

Have you made any previous partner pregnant? Yes No

If yes, give the date and outcome of pregnancies (i.e. spontaneous abortion, induced abortion, caesarean section, still birth, ectopic pregnancy, premature birth, normal delivery)

Date Outcome

Pregnancy #1 _____
Pregnancy #2 _____
Pregnancy #3 _____

For how many months have you used the following contraception methods and when did you discontinue use?

Condom: _____
Diaphragm: _____
Foam: _____
IUD: _____
Pills: _____
Rhythm: _____

Have you ever undergone sterilization/vasectomy? Yes No
Has your partner ever undergone sterilization? Yes No
Have you been examined for infertility problems elsewhere? Yes No
Have you received treatment for infertility problems elsewhere? Yes No
Has your partner been examined for fertility problems? Yes No
Has your partner been using an ovulation kit? Yes No
Do you have intercourse every day or every other day during the ovulation cycle? Yes No

Has your current partner had any pregnancies previously with someone other than you? Yes No

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If yes, give the date and outcome of pregnancies (i.e. spontaneous abortion, induced abortion, caesarean section, still birth, ectopic pregnancy, premature birth, normal delivery)

Date Outcome

Pregnancy #1 _____

Pregnancy #2 _____

Pregnancy #3 _____

Do you ejaculate into your partner's vagina?	Yes	No
Is her vagina ever so tight that you cannot penetrate?	Yes	No
Do you use any form of lubrication for intercourse?	Yes	No
Does your partner often have vaginal infections?	Yes	No
Does your partner douche immediately following intercourse?	Yes	No
Does your partner usually get out of bed immediately following intercourse?	Yes	No
Are your partner's menstrual periods irregular?	Yes	No
Has your partner had any of the following illnesses?		
a. Pelvic inflammatory disease	Yes	No
b. Sexually transmitted infection	Yes	No
Has your partner had surgery on her tubes or ovaries?	Yes	No

Sexual History

Please rate your current level of sexual desire/libido on a scale from 0 – 10, 0 = none and 10 = you can't stop thinking about sex: _____/10

How often do you attempt intercourse? _____

Do you often lose your erection during intercourse?	Yes	No

How many times per week do you masturbate? _____

Please rate your level the hardness of your erections.

0 - Penis does not enlarge.

3 - Penis is larger, but not hard.

5 - Penis is full, but not hard enough for vaginal penetration.

6 - Penis is just hard enough for vaginal penetration, but not completely hard.

10 - Penis is completely hard and fully rigid. ____/10

Are you able to have a climax or orgasm?	Yes	No
Does semen (fluid/cum) come out of your penis when you have orgasm?	Yes	No
Do you usually ejaculate prior to penetration for intercourse?	Yes	No

About how long does intercourse last before you ejaculate (cum)? _____minutes

Do you have premature ejaculation? Yes No

If yes, when did this start? _____

How well are you able to control it?	Poor	Fair	Good	
How much does it bother you?	None	Minimal	Moderate	Severe
How much does it bother your partner?	None	Minimal	Moderate	Severe