monica patt
ACUPUNCTURE

10118a 124 Street
Edmonton, Alberta T5N 1P6
780.705.0444

Male Fertility Intake Supplementation

Date (m/d/y):

Name : DOB(m/d/y): Age:

How long have you been trying to conceive?

Have you received a diagnosis related to infertility? Y N Diagnosis:

Do you have any children? Y N If yes, is current partner the mother? Y N

Do you have other children from previous relationships? Y N #

Sexual History

☐Erectile Dysfunction	☐High libido	☐History of steroid use	☐Hernia ☐Repaired
☐Premature Ejaculation	☐Low libido	☐Exposure to pesticides/chemicals	☐Vasectomy ☐Reversed
☐Testicular Trauma	☐Prostatitis	☐Cancer/chemo treatment	
☐Dizzy/tired after ejaculations	☐Genital Herpes	☐Varicocele ☐Repaired	

☐Sexually Transmitted Disease History

Have you had your testosterone levels checked? Y N

When (m/d/y): Results:

☐Semen Analysis When (m/d/y): Antibodies? Y N

If yes what were the results for Motility:

Morphology:

Volume:

Has your partner undergone IUI? Y N

If yes ☐Your sperm ☐Donor Sperm

#IUI's: _____

Dates: _____

Results: _____

Has your partner undergone IVF? Y N

If yes ☐Your sperm ☐Donor Sperm

#IUI's: _____

Dates: _____

Results: _____