Stony Brook Medicine

School of Medicine
Department of Urology
Tel. 631-444-1919

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_____
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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

l . 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_____
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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_____
11. 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:_____