

Men's Fertility History

Fertile Lifestyle 7850 Mission Center Court, Suite 207, San Diego, Ca,
92108 (760)419-6863

Name: _____

Date: _____

How long have you and your partner been trying to conceive?

Please circle your answers for the questions below

How is your sexual energy? Low Normal High

Do you have (or have had) an undescended testicle(s)? Yes
No

Have you ever been diagnosed with a varicocele? Yes
No

Have you had any urological surgeries? Yes
No

Have you had a vasectomy reversed? Yes
No

Have you experienced difficulty ejaculating? Yes
No

Have you experienced difficulty maintaining an erection? Yes
No

Have you been exposed to any known environmental
toxins or hormones? Yes No

Do you smoke cigarettes or marijuana? Yes
No

Have you experienced any irregular penile discharge? Yes
No

Do you regularly experience ejaculation while sleeping? Yes
No

Have you had a sperm analysis? Yes
No

If yes, what was your sperm count? Below normal or Normal
Number _____

What was the sperm motility? Below normal or Normal
Notes _____

What was the sperm morphology? Below normal or Normal
Notes _____

Please list any prescription medication that you are currently taking:

Please list any non-prescription medication that you are currently taking including herbs, vitamins and over the counter medications: _____
