**Addition Information – Infertility**

Welcome to the office! Date: \_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_

Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province of issue: AB Other: \_\_\_\_\_

For **HER**:

Age at first period: \_\_\_\_\_\_\_\_

How **long** have you been trying to get pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have intercourse (sex) on a regular basis? YES NO

Are you taking prenatal vitamins? YES NO

Any **breast** leaking, discharge or changes? YES NO

Have any tests/investigations have been done yet? YES NO

 If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For **HIM** (answer to the best of your ability):

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_

Does he smoke **cigarettes**? YES NO If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does he smoke **marijuana**? YES NO If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does he use **anabolic steroids** or **weight gain supplements**? YES NO

Has he had a **semen analysis**? YES NO

Would he be **willing** to get one? YES NO

Does he have any problems with **getting** an erection? YES NO

Does he have any problems **keeping** an erection? YES NO

Does he **ejaculate**? YES NO

Does he have any **other children** or **conceptions** from previous relationships? YES NO

 Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To the best of your knowledge…**

Did he have mumps as a child? YES NO

Any straddle injuries or groin injuries as a child? YES NO

Please list anything that is relevant with respect to the following:

Ongoing health concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_