REGISTRATION FORM

Male

First Name…… Last Name……..

Home Address…… Work Address……

Ph.No…….. Ph.No……..

E-mail address……..

May we e-mail documents to you ……. Yes/No

Occupation ……..

Referred by : Dr…… Dr contact……..

number/email……```

Date

Can we contact you after sometime to enquire about your feedback on this

consultation …… Yes/No/Maybe

MALE MEDICAL HISTORY

Age:……..Yrs. HT: ..... CM WT……..Kgs BMI……

- Have you been married before?
- Do you already have children? If yes, please give details. …….. Yes/No

- Have you had infertility tests or infertility treatment in the past? If yes, when? .....Where? Yes/No

Have you ever had any sexually transmitted disease? Yes/No
Gonorrhea/Syphilis/Chlamydia/Others

If yes. When……Was it treated?..... Yes/No

- Did you ever have loss or lack of sexual desire…… Yes/No
- Do you have trouble in getting an erection/maintaining an erection/ejaculation? Yes/No
- Do you have any other sexual problems? Yes/No
- Did you ever have pain during urination/erection/ejaculation?..... Yes/No
- Did you ever have blood in urine/ejaculate Yes/No
- Have you had injury or infection to the testes/Genitalia Yes/No
- Have you had or do you have undescended testes?..... Yes/No

Social History

- Do you smoke? Yes/No
  If Yes, How many per day?……
- Have you ever used any recreational drugs in the last 5 days? Yes/No
  If yes, what and when?.....
- Do you drink alcohol per week?..... Yes/No
  (1 unite is a standard glass of wine, half a pint of beer or a single measure of sprits)

Surgical History

- Have you had any operation on the testes/groin/hernia/genitalia?..... Yes/No
- Have you had any other surgeries/procedure in abdomen? Yes/No
  (if Yes to either, please give details in the table below.)

Hospital	Year Date	Details of Surgery

Medical History

• Have you had any serious illnesses in the past? . Yes/No
(if Yes; please give details)…….

Medical Problem	Yourself Yes/No	Your relatives Yes No	Explain
Tuberculosis			
Diabetes			
Psychiatric problems/ Depression			
Hepatitis or Jaundice			
HIV+ Ve test			
Raised blood pressure			
Cancer			
Rheumatoid arthritis			
Immune problems			
Asthma			
Other			

- Have you had mumps since puberty? Yes/No
- Have you had a fever during the past 3-4month? Yes/No

Allergies

- Do you have any sensitivity to drugs/objects?
- Have you had any reaction to local or general anesthetic? Yes/No

Please specify any allergies in the table below:

Allergy to any medication /Latex /Nuts / Eggs /Soya Milk products	Type of reaction

Medication:

- Have you Ever used Hormones, Steroids, Pain Killers, Immuno-suppressants, special medications, Vitamins, Homeopathics /Ayurvedic preparations Yes/No

Please give details……

Are you currently on any of the above medications Yes/No

Medication	Dose	Frequency

Male investigations

Semen Analysis;

Center/Date	Volume. mls	Total count millions	Density Mil m	%Total motility	%Rapid motility	Morphology	Viscosity	Vitality	White cells

-Must attach copy of all reports without fail-

Male Investigations-other

TEST	Result Date	Result Date	Result Date	Result Date	Result Date	Comments
FSH						
L.H						

Male Investigations-other (Continued):

Testosterone						
TSH						
Estradiol						
PRL						
Chlamydia (igG/ lgM)						
HIV I & Il						
Hepatitis B						
Hepatitis C						
Sperm (DNA Fragmentation)						
Karytoype						
Y deletion						
Sperm C/S						
Sperm aneuploidy						

Is there any difficulty providing semen sample in the hospital? Yes/No

Requires any medication/special assistance to provide semen sample in hospital?

Yes/No

Is there any Sperm Stored in past, for any reason? Yes/No

I here by state that the information provided by me are correct to the best of my knowledge, if any information provided herein need correction on a later date, I would do so without fail as I understand that accuracy of the information provided herein could have a bearing on the treatment rendered and / or envisaged. Signature & Date