Fertile Lifestyle Acupuncture & Integrative Medicine

Men's Fertility History

Name: _____

Date: _____

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

Please circle your answers to the questions below.

How is your libido? Low Normal High

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 any difficulty ejaculating?	Yes	No
Have you experienced and difficulty maintaining an erection?	Yes	No
Have you been exposed to any environmental toxins?	Yes	No
Do you smoke cigarettes or marijuana (edibles)?	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? _____

What was your sperm motility? _____

What was your sperm morphology? (Krueger score) _____

Please list any prescription medication that you are currently taking.

_____

Please list any non-prescription medication that you're currently taking (including herbs, vitamin supplements, and over the counter medication.)

_____