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[www.reproductiveassociates.org](http://www.reproductiveassociates.org)

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## PARTNER HEALTH QUESTIONNAIRE

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Race: \_\_\_\_\_ Religion: \_\_\_\_\_ Blood type: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Duration of infertility: \_\_\_\_\_

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

Current medications/  
 supplements/vitamins/over-  
 the-counter medications: \_\_\_\_\_

### MEDICAL PROBLEMS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### SURGERY HISTORY (type of surgery, date, physician):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### SOCIAL HISTORY

Hobbies: \_\_\_\_\_

Alcohol: \_\_\_\_\_ Tobacco: \_\_\_\_\_ Recreational Drugs: \_\_\_\_\_

Exercise and frequency \_\_\_\_\_

Have you ever received counseling? Yes / No

If so, for what reason? \_\_\_\_\_

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

### Have You Ever Had:

Children with another partner?	Yes	No	
Surgery or injury to penis/testicles	Yes	No	
Sexually transmitted disease (including gonorrhea, chlamydia, HIV, HPV and herpes)	Yes	No	
Heat or radiation exposure	Yes	No	
Any problems with the prostate gland	Yes	No	
Mumps after puberty	Yes	No	
Semen analysis	Yes	No	Date:
Blood transfusion	Yes	No	
Hepatitis	Yes	No	

### FAMILY HISTORY

		Who In Family?
<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	Tuberculosis	
<input type="checkbox"/>	High blood pressure	
<input type="checkbox"/>	Heart disease	
<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	Birth defects/mental retardation	
<input type="checkbox"/>	Kidney/Urinary disease	
<input type="checkbox"/>	Mental illness	
<input type="checkbox"/>	Hemophilia	
<input type="checkbox"/>	Asthma/Allergy	
<input type="checkbox"/>	Twins/Triplets	
<input type="checkbox"/>	Epilepsy/Convulsions	
<input type="checkbox"/>	Other	