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

How is your sexual energy?

◯ Low ◯ Normal ◯ High

Do you have an undescended testes?

◯ Yes ◯ No

Have you ever been diagnosed with a varicocele?

◯ Yes ◯ No

Have you had any urologic surgeries?

◯ Yes ◯ No

Have you had a vasectomy reversed?

◯ Yes ◯ No

Have you experienced difficulty maintaining erection?

◯ Yes ◯ No

Have you experienced difficulty ejaculating?

◯ Yes ◯ No

Have you been exposed to any known environmental toxins or hormones?

◯ Yes ◯ No

Do you smoke?

◯ Yes ◯ No

Have you experienced any penile discharge?

◯ Yes ◯ No

Do you regularly experience nocturnal emission?

◯ Yes ◯ No

Have you had a fertility workup?

◯ Yes ◯ No

If yes, what was your sperm count?

◯ Below normal ◯ Normal

Number

What was the sperm motility?

◯ Below normal ◯ Normal

Notes

What was the sperm morphology?

◯ Below normal ◯ Normal

Notes

Please list any prescription medications you are currently taking:

Record

Please list any non-prescription medications you are currently taking, including herbs, supplements, and over-the-counter medications:

Record

Notes:

Record