Baystate Health | ADVANCING CARE. ENHANCING LIVES.

# PARTNER INTAKE FORM

____/____/____
Month day year

NAME: _____ _____ AGE: _____ DOB: ____/____/_____
LAST FIRST Month day year

PARTNER'S NAME: _____ _____ AGE: _____ DOB: ____/____/_____
LAST FIRST Month day year

Referring Physician: _____ Primary Care Physician: _____

REASON FOR VISIT: ☐ Infertility ☐ Other
_____

IF TRYING TO CONCEIVE, HOW LONG? ☐ Yes_____ years OCCUPATION:
_____

***Please answer the following questions, if applicable. Make any comments in the comments section at the bottom of this page.***

Number of pregnancies with current partner: _____

Number of years married: _____ years

Number of prior marriages: Husband _____ Wife _____

Number of pregnancies with previous partner(s) _____

Age(s) of children, if any _____

**Past Medical History**

Do you have any heart problems? ☐ Yes ☐ No

Do you have any lung problems (asthma, etc)? ☐ Yes ☐ No

Do you have bowel or stomach problems? ☐ Yes ☐ No

Problems with muscles or joints? ☐ Yes ☐ No

Ever had mumps? ☐ Yes ☐ No

Do you have any neurological problems? ☐ Yes ☐ No

Any hormonal problems (thyroid, diabetes etc.)? ☐ Yes ☐ No

Do you have any other medical problems?

_____

_____

_____

Have you had any other surgery?

_____

_____

List any medications you are now taking?

_____

_____

**Urological History FOR MALES ONLY**

Have you ever had undescended testicles? ☐ Yes ☐ No

Have you ever suffered an injury to the testicles? ☐ Yes ☐ No

Have you ever had a hernia repair? ☐ Yes ☐ No

Have you been diagnosed with a varicocele? ☐ Yes ☐ No

Have you had a vasectomy? ☐ Yes ☐ No

Have you had a vasectomy reversal? ☐ Yes ☐ No

Have you had a bladder or prostate surgery? ☐ Yes ☐ No

Do you have a problem with achieving erections? ☐ Yes ☐ No

Have you had epididymitis? ☐ Yes ☐ No

Ever had a Urinary Tract Infection? ☐ Yes ☐ No

Ever had a sexually transmitted disease? ☐ Yes ☐ No

Any problems with ejaculation? ☐ Yes ☐ No

Any problems with sex drive? ☐ Yes ☐ No

Did you have early puberty (before 12 yrs)? ☐ Yes ☐ No

Did you have late puberty ☐ Yes ☐ No

Have you had abnormal sexual development? ☐ Yes ☐ No

Have you had a fever within the last 3 months? ☐ Yes ☐ No

Other family members have a fertility problem? ☐ Yes ☐ No

ALLERGY TO MEDICATIONS: ☐ Yes ☐ No

_____

_____

## Social

Any special exposure to heat on a regular basis (sauna, baths, Jacuzzi)? ☐ Yes ☐ No

Have you been exposed to any chemicals? ☐ Yes ☐ No

Have you been exposed to radiation (not routine x-rays)? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

How many drinks of alcohol per week?_____

Ancestral background of parents'_____

***Comments on any of the above:***

_____

_____

_____

## Partner's Family History

*Has anybody in your family had any of the following?*

| | | | |
|---|---|---|---|
| Early menopause | ☐ Yes ☐ No | Breast cancer | ☐ Yes ☐ No |
| Ovarian cancer | ☐ Yes ☐ No | Muscular dystrophy | ☐ Yes ☐ No |
| Stillbirth | ☐ Yes ☐ No | Sickle-cell anemia | ☐ Yes ☐ No |
| Cystic fibrosis | ☐ Yes ☐ No | Mental retardation | ☐ Yes ☐ No |
| Tay-Sachs | ☐ Yes ☐ No | Spina bifida | ☐ Yes ☐ No |
| Down's Syndrome | ☐ Yes ☐ No | Tuberous sclerosis | ☐ Yes ☐ No |
| Birth defects | ☐ Yes ☐ No | Heart attack (<50yrs) | ☐ Yes ☐ No |
| Thyroid disease | ☐ Yes ☐ No | Psychiatric disease | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | Blindness | ☐ Yes ☐ No |
| High blood press. | ☐ Yes ☐ No | Chromosome problem | ☐ Yes ☐ No |
| Hemophilia | ☐ Yes ☐ No | Recurrent miscarriage | ☐ Yes ☐ No |
| Deafness | ☐ Yes ☐ No | Other/Genetic Issues: | ☐ Yes ☐ No |
| Polycystic kidneys | ☐ Yes ☐ No | _____ | |
| Bleeding disorders | ☐ Yes ☐ No | _____ | |