CLINIQUE ASIATIQUE

NAME (LAST, FIRST, MIDDLE)	AGE	DATE

FERTILITY EVALUATION:

Date of birth ______________________________

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

____

How frequently do you & your partner have intercourse?

____

Have you ever gotten someone else pregnant?
☐ yes ☐ no

How would you describe your stress level?
☐ low ☐ normal ☐ high

How would you describe your sexual energy?
☐ low ☐ normal ☐ high

Do you exercise regularly? ☐ yes ☐ no
Type: ____________________ hrs/week: _____
Type: ____________________ hrs/week: _____

FERTILITY HISTORY:

Have you ever had any significant testicular injury?
☐ yes ☐ no
If yes, please describe: ____________________

____

Do you take hot baths? ☐ yes ☐ no
If yes, how many per week: __________________

Do you regularly experience nocturnal emission?
☐ yes ☐ no
If yes, how many times per week: ______________

Have you experienced difficulty ejaculating?
☐ yes ☐ no

Have you experienced maintaining an erection?
☐ yes ☐ no
If yes, have you taken medication?
☐ yes ☐ no
What type? ____________________________

Do you have heat or cold intolerance?
☐ yes ☐ no
Which? ______________________________

Have you ever had any of the following procedures done?
- ☐ Varicocele repair
- ☐ Hernia repair
- ☐ Prostate surgery
- ☐ Testicular torsion repair
- ☐ Testicular biopsy
- ☐ Vasectomy reversal
- ☐ Other ________________________

Have you had a semen analysis performed?
☐ yes ☐ no
If yes, when: ____________________________
Sperm count: ☐ normal ☐ below normal
Value: ____________________________
Morphology: ☐ normal ☐ below normal
Value: ____________________________
Motility: ☐ normal ☐ below normal
Value: ____________________________

Please list any supplements you have taken to enhance fertility: (please attach additional pages if necessary)

Type	How long	Noticeable result(s)

Primary Care MD: ____________________________
Tel #: ____________________________

OTHER:

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