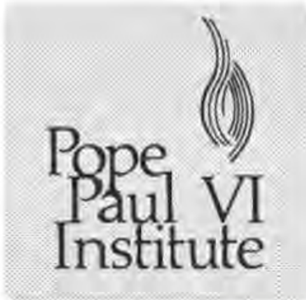

NaProTECHNOLOGY

Male General Information Form

Pope Paul VI Institute • 6901 Mercy Road • Omaha, NE 68106 • Ph# 402-390-6600 • Fax # 402-390-9851

Date: ____________________

Name: ____ Age: ______ DOB: ____________________
Last First

Name of spouse: ____________________________________ Age: ______ DOB: ____________________
Last First

Referring physician: ______________________________ Primary care physician: ______________________

Number of years married: ______ Number of prior marriages: ______

Age(s) of children, if any: ______ Number of pregnancies with previous spouse: ______

Past Medical History

Please circle the appropriate answer:

Had mumps	yes	no	Lung problems (asthma, etc.)	yes	no
Heart problems	yes	no	Muscle or joint problems	yes	no
Hormonal problems (thyroid, diabetes, etc.)	yes	no	Neurological problems	yes	no
			Stomach problems	yes	no
Other medical problems	yes	no	Other surgery	yes	no

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Current medications	yes	no

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ALLERGY to medications	yes	no

Male History

Please circle the appropriate answer:

Abnormal sexual development	yes	no	Puberty was late	yes	no
Bladder or prostate surgery	yes	no	Sex drive problems	yes	no
Ejaculation problems	yes	no	Sexually transmitted disease	yes	no
Epididymitis	yes	no	Undescended testicles	yes	no
Fever within the last three months	yes	no	Urinary tract infection	yes	no
Had hernia repair	yes	no	Varicocele diagnosis	yes	no
Injury to the testicles	yes	no	Vasectomy	yes	no
Problem achieving erections	yes	no	Vasectomy reversal	yes	no
Puberty was early (<12 years)	yes	no	Other family member with fertility problem	yes	no

Social History

Please circle the appropriate answer:

Drink alcohol (# drinks/week___)	yes	no	Regular exposure to heat (sauna, baths, jacuzzi)	yes	no
Exposure to chemicals	yes	no	Smoker (# packs/day___)	yes	no
Radiation exposure (not routine x-rays)	yes	no			
Recreational drugs	yes	no			

Family History

Has anybody in your family had any of the following:

Blindness	yes	no	Mental retardation	yes	no
Birth defects	yes	no	Muscular dystrophy	yes	no
Chromosome problem	yes	no	Polycystic kidneys	yes	no
Cystic fibrosis	yes	no	Psychiatric disease	yes	no
Deafness	yes	no	Sickle-cell anemia	yes	no
Diabetes	yes	no	Spina bifida	yes	no
Down syndrome	yes	no	Tay-Sachs disease	yes	no
Heart attack (<50 years)	yes	no	Thyroid disease	yes	no
Hemophilia	yes	no	Other genetic disorders	yes	no
High blood pressure	yes	no			

Ancestral Background

There are certain ancestral backgrounds that have an increase frequency of some genetic disease. Please indicate if either your mother or father are of any of the following backgrounds:

- ☐ African
- ☐ Asian
- ☐ Caribbean
- ☐ French Canadian
- ☐ Indian
- ☐ Jewish
- ☐ Latin American
- ☐ Mediterranean
- ☐ Native American
- ☐ None of the above

Other Possible Concerns

Please circle the appropriate answer:

Biopsy of testicles	yes	no	Physical abnormality	yes	no
Cancer	yes	no	Prostatitis	yes	no
Colitis	yes	no	Psychiatric treatment	yes	no
DES exposure in womb	yes	no	Seizures	yes	no
Diabetes	yes	no	Strenuous exercise	yes	no
Genital herpes	yes	no	Tight underwear	yes	no
Genital warts/condyloma	yes	no	Varicocele	yes	no
High blood pressure	yes	no	Varicocele surgery	yes	no
Mumps with injury to testicles	yes	no	Urethritis/epididymitis	yes	no
Penile discharge or pain	yes	no			

Comments

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