Health Questionnaire for Male Infertility Patients

Name: _____

DOB: _____ Date: _____

MEDICAL HISTORY	YES	NO	ADDITIONAL INFORMATION
Diabetes			
Epilepsy			
Clots in legs/lungs			
High Blood Pressure			
Heart problems			
Kidney/Liver problems			
Thyroid problems			
Back problems			
Depression			
Thalassemia			
Infertility Treatment			
Have you had a general anesthesia?			
Did you have any problems?			
Any other relevant Medical/Surgical History			
Any known Infectious Diseases?			

Family History	Yes	No	Additional Information

Diabetes			
Heart Disease			
High Blood Pressure			
Cancer			
Clots in the legs or lungs			
Cystic Fibrosis			
Down's Syndrome			
Kidney Disease			
Spina Bifida			
Thalassemia			
Congenital abnormalities			
Genetic Illnesses			
Any other illness			

Please List any operations and year:

Type of Operation	**Year**

Please list Current medications and dosages:

Name	**Dosage**

Social History	**Yes**	**No**	**Additional Information**
Drug Allergies			

Non drug Allergies			
Smoker			
Alcohol			
Recreational drugs			

General

Have you had any history of pelvic infection or sexually transmitted diseases?	Yes	No
How do you describe your diet?		
Very healthy Balanced Reasonably healthy Unhealthy (Please circle)		
Do you eat fruit and vegetables?	Yes	No
Are you taking any Supplements?	Yes	No
Do you experience any sexual problems?	Yes	No
Have you had any tests for fertility?	Yes	No
Have you fathered any children?	Yes	No
Have you had Mumps:	Yes	No
Have you had any genital infections?	Yes	No
Have you had any genital trauma?	Yes	No
Do you have any significant past or present medical history?	Yes	No
Do you have a history of:		
Hernia	Yes	No
Vasectomy	Yes	No
Undescended testes	Yes	No
Any other operations not previously listed?		
Any other relevant information.		

PERSONAL DETAILS

Title _____Given Name: _____ Surname:_____

Address: _____**Postcode:** _____

Postal Address: _____**Postcode:** _____

Date of Birth: _____ **Home Phone:** _____

Work Phone: _____ **Mobile Phone:** _____

Email: _____

Occupation: _____

Next of Kin: _____ **Relationship:**_____

Next of Kin Contact Number: _____

Current GP: _____

Medicare Number: _____**Ref:** _____ **Expiry:** _____

Health Fund: _____**Membership Number:** _____

Special Interest: _____

How did you hear about us? GP/Specialist /Advertising /Friend/Family /Google /Internet

Other:_____

CONSENT TO RELEASE OF MEDICAL INFORMATION

I give my consent to NG Gynehealth, or their agents and advisors, to contact medical practitioners or other bodies I have consulted to obtain health and other information that may be pertinent to my care.

I authorize those medical practitioners or bodies to release such information, which may include sensitive health information, to NG Gynehealth, or their agents and advisors, as may be requested.

I understand that unless I advise otherwise, NG Gynehealth will continue to liaise with the doctors nominated above on matters related to my ongoing care.

OTHER

I give permission for NG Gynehealth to contact me via SMS/Phone regarding appointment details and results.
I give permission for NG Gynehealth to contact me through email.
I give permission to NG Gynehealth to take clinical photographs and use them for educational purposes.
I give permission to NG Gynehealth to take identification photographs to attach to my clinical chart.
I understand it is my responsibility to call the clinic for results**.**

Privacy Statement

Your information will be kept confidential in this practice at all times. All our staff are governed by the Policy Act of 1988. If you have any concern regarding your privacy being disclosed, please discuss this with your Doctor.

I consent to the collection and release of personal information about me to other healthcare professionals when it is relevant to my health and care.

Signature: _____ Date: _____