Xu Wellness Center
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Men's Fertility Information

Name	Date	Age
Spouse's/ Partner's Name	Occupation	
Doctor	Fertility Clinic	

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

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Have you had a fertility workup? If yes, what were the results? _______________________

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Have you been given a diagnosis relating to infertility? If yes, please explain: _________

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Is there a history of infertility in your family? If yes, please explain: __________________

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Is there history of any genetic birth defects or mental retardation in your family? If yes, please explain: ____

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Have you fathered any children in the past? If yes, was it naturally and was it with your current partner? ____

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Have you been exposed to any known environmental toxins? If yes, please explain:

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Do you smoke? If yes, how much? ____

Do you consume soy products? If yes, how often: ________________________________

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Do you have a healthy body weight? If no, explain: ______________________________

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Do you have an unhealthy diet? If yes, please list the unhealthy foods and drinks that you consume regularly, along with the frequency: ______________________________

____

Do you use any recreational drugs? If yes, what and how often: __________________

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Are you stressed often? ____

How is your sexual energy? ____

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Do you often wake up to urinate? If yes, how frequently? ________________________

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Have you had a vasectomy reversed? If yes, when: ______________________________

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Have you ever or do you presently suffer with any of the following:

☐ Urologic Surgeries	☐ Undescended Testes	☐ Varicocele
☐ Difficulty Maintaining an Erection	☐ Difficulty Ejaculating	☐ Nocturnal Emission
☐ Penile Discharge	☐ Low Testosterone	☐ Low Sperm Count
☐ Prostatitis	☐ Swollen Scrotum	☐ Seminal Duct Blockage

☐ Falling/ Painful Testicles	☐ Low Sperm Motility	☐ Low Sperm Morphology
☐ Herpes	☐ Chlamydia	☐ HIV/ AIDS
☐ Gonorrhea	☐ Poor Sperm Liquefaction	☐ Genital Warts
☐ HPV	☐ Other STDs:	