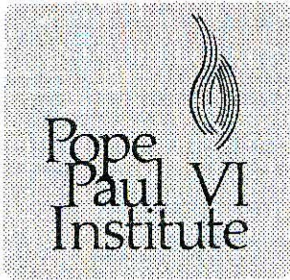


# NaProTECHNOLOGY

## Male General Information Form

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

Date: ____________________

Name: ______________________________ (Last / First) Age: ______ DOB: ____________________

Name of spouse: ______________________________ (Last / First) Age: ______ DOB: ____________________

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 |
| Heart problems | yes | no |
| Hormonal problems (thyroid, diabetes, etc.) | yes | no |
| Other medical problems | yes | no |

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| | | |
|---|---|---|
| Current medications | yes | no |

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| | | |
|---|---|---|
| Lung problems (asthma, etc.) | yes | no |
| Muscle or joint problems | yes | no |
| Neurological problems | yes | no |
| Stomach problems | yes | no |
| Other surgery | yes | no |

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| | | |
|---|---|---|
| ALLERGY to medications | yes | no |

### Male History

*Please circle the appropriate answer:*

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