



**Reproductive Associates of Delaware**

NEWARK • DOVER • WILMINGTON

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## PARTNER HEALTH QUESTIONNAIRE

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Race: \_\_\_\_\_ Religion: \_\_\_\_\_ Blood type: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Duration of infertility: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current medications/  
supplements/vitamins/over-  
the-counter medications: \_\_\_\_\_

### MEDICAL PROBLEMS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### SURGERY HISTORY (type of surgery, date, physician):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### SOCIAL HISTORY

Hobbies: \_\_\_\_\_

Alcohol: \_\_\_\_\_ Tobacco: \_\_\_\_\_ Recreational Drugs: \_\_\_\_\_

Exercise and frequency \_\_\_\_\_

Have you ever received counseling? Yes / No

If so, for what reason? \_\_\_\_\_

Name: \_\_\_\_\_

**Have You Ever Had:**

Children with another partner?	<b>Yes</b>	<b>No</b>	
Surgery or injury to penis/testicles	<b>Yes</b>	<b>No</b>	
Sexually transmitted disease (including gonorrhea, chlamydia, HIV, HPV and herpes)	<b>Yes</b>	<b>No</b>	
Heat or radiation exposure	<b>Yes</b>	<b>No</b>	
Any problems with the prostate gland	<b>Yes</b>	<b>No</b>	
Mumps after puberty	<b>Yes</b>	<b>No</b>	
Semen analysis	<b>Yes</b>	<b>No</b>	Date:
Blood transfusion	<b>Yes</b>	<b>No</b>	
Hepatitis	<b>Yes</b>	<b>No</b>	

**FAMILY HISTORY**

		Who In Family?
<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	Tuberculosis	
<input type="checkbox"/>	High blood pressure	
<input type="checkbox"/>	Heart disease	
<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	Birth defects/mental retardation	
<input type="checkbox"/>	Kidney/Urinary disease	
<input type="checkbox"/>	Mental illness	
<input type="checkbox"/>	Hemophilia	
<input type="checkbox"/>	Asthma/Allergy	
<input type="checkbox"/>	Twins/Triplets	
<input type="checkbox"/>	Epilepsy/Convulsions	
<input type="checkbox"/>	Other	