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FERNALD MEDICAL MONITORING PROGRAM

MALE REPRODUCTIVE HISTORY

In order to have complete information for your Medical Monitoring Program record, we need to know about your reproductive health. After you have completed this form, please place it in the attached envelope, seal the envelope, and place in the large mailing envelope for return to the program office.

YOUR DATE OF BIRTH: _____ ____, 19 __ __

TODAY'S DATE: _____ ____, 19 __ __

The first part of this form asks questions about pregnancies you have fathered during your lifetime. In answering these questions, please:

a. Include ALL pregnancies - those that ended in miscarriages or spontaneous abortions, stillbirths, induced or planned abortions, or tubal or ectopic pregnancies, as well as those that ended as live births.

b. Include pregnancies of your current wife or partner as well as previous wives or partners.

c. Count twins or triplets as a single pregnancy.

1. How many pregnancies have you fathered during your lifetime?

__ __ pregnancies

IF YOU HAVE NEVER FATHERED A PREGNANCY, PLEASE GO TO QUESTION #5 ON PAGE 4.

IF YOU HAVE FATHERED ONE OR MORE PREGNANCIES, PLEASE COMPLETE THE CHART ON THE BACK OF THIS PAGE.

2. Please give the following information about the children you fathered who were **alive at birth.** Report all birth defects or abnormalities, even if they were not recognized at birth.

	SEX	**DATE OF BIRTH** (month, day, year) Use "DK" for "don't know".	**BIRTH DEFECTS OR ABNORMALITIES**	**DESCRIBE DEFECT OR ABNORMALITY**	**WIFE/PARTNER:** **# OF MONTHS PREGNANT AT BIRTH** (full term = 9 months)
CHILD #1 (oldest)	M F	__ __/__ __ 19 __ __	No Yes		__ months
CHILD #2	M F	__ __/__ __ 19 __ __	No Yes		__ months
CHILD #3	M F	__ __/__ __ 19 __ __	No Yes		__ months
CHILD #4	M F	__ __/__ __ 19__ __	No Yes		__ months
CHILD #5	M F	__ __/__ __ 19__ __	No Yes		__ months
CHILD #6	M F	__ __/__ __ 19__ __	No Yes		__ months
CHILD #7	M F	__ __/__ __ 19__ __	No Yes		__ months
CHILD #8	M F	__ __/__ __ 19__ __	No Yes		__ months

If you have fathered more than eight children who were alive at birth, please list other children on back of the last page of this form, and sex, date of birth, etc.

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3. How many pregnancies did you father that were **ended by medical or surgical means**, and did not result in a live birth? By this, we are referring to pregnancies such a **tubal or ectopic pregnancy, or induced or planned abortion.** In this number, **do not** include pregnancies that ended as a miscarriage or stillbirth which was followed by a D&C.

__ __ pregnancies

4. Please give information about pregnancies that you fathered that ended as a **miscarriage or stillbirth.**

	DATE OF MISCARRIAGE OR STILLBIRTH: (month, day, year) Use "DK" for "don't know".	**WIFE/PARTNER: # OF MONTHS PREGNANT WHEN PREGNANCY ENDED**	**BIRTH DEFECT** (if known)
Miscarriage or stillbirth #1	__ __/__ __ 19__ __	__ months	
Miscarriage or stillbirth #2	__ __/__ __ 19__ __	__ months	
Miscarriage or stillbirth #3	__ __/__ __ 19__ __	__ months	
Miscarriage or stillbirth #4	__ __/__ __ 19__ __	__ months	

5. Have you and your wife/partner ever tried to conceive ("get pregnant") for more than a one year time period?

_____ No _____ Yes

IF YES, please give the approximate dates for the first time period.

FROM: _____ 19__ __ TO: _____ 19 __ __
Month Month

Was there more than one period of time? __ No __ Yes

Did your wife/partner eventually get pregnant? __ No __ Yes

__ __ __ __ __

6. Have you and your wife/partner ever seen a doctor because you had difficulty in conceiving ("getting pregnant")?

____ No ____ Yes

IF YES,
Was the doctor's diagnosis?
(Check all that apply.)

___ some problem with your wife/partner
___ some problem with you
___ no cause identified
___ don't know

7. Have you ever had a sperm analysis?

__ No __ Yes

IF YES,
When did you have your first sperm analysis?

_____, 19 __ __
Month

Why did you have the sperm analysis?

_____

What was the result of your sperm analysis?
(Check all that apply.)

low sperm count ___
poor motility (movement) ___
high sperm count ___
low volume ___
abnormal shapes ___
poor speed ___

abnormal but don't know specifics ___

other _____ ___

__ __ __ __ __

8. Have you ever been told by a doctor that you had any of the following conditions? (Check all that apply.)

			Year Diagnosed
a.	only one testicle	___	19 __ __
b.	mumps involving the testicle(s)	___	19 __ __
c.	injury to the testicle	___	19 __ __
d.	infection of the testicle(s)	___	19 __ __
e.	infection of the seminal vessels	___	19 __ __
f.	infection of the epididymis	___	19 __ __
	SEXUALLY TRANSMITTED OR VENERAL DISEASES		
g.	chlamydia	___	19 __ __
h.	syphilis	___	19 __ __
i.	gonorrhea (clap, drip)	___	19 __ __
j.	genital herpes	___	19 __ __
k.	other _____	___	19 __ __

9. Have you ever had a testicular biopsy or had a testicle removed?

			Year of Surgery
a.	testicular biopsy	___	19 __ __
b.	removal of a testicle	___	19 __ __

10. Have you ever had a vasectomy?

____ No ____ Yes

IF YES,
When did you have it? 19 __ __

Have you tried to have it reversed?

__ No __ Yes If yes, when? 19 __ __

Thank you for completing this form. Please remember to put it in the attached white envelope, seal the envelope, and then place the sealed envelope in the large mailing envelope.

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