MALE MEDICAL QUESTIONNAIRE

This questionnaire must be completed & received prior to your initial consultation with Dr. Silber.

Date: _____

Legal Name: _____

Last Name First Name Nickname

Date of Birth: _____ Height: _____ Weight:_____

mm/dd/yyyy feet/inches pounds

Home address _____ Social Sec.# _____

City, State, Zip _____

Home Phone (____)_____ Circle one: single engaged married

Cell Phone (____)_____

Work Phone (____)_____ Email address _____

Employer _____ Occupation _____

Ethnicity:

☐ White ☐ Black or African American

☐ Hispanic ☐ Native American or other Pacific Islander

☐ Asian ☐ American Indian or Alaska Native

☐ Refused

How long have you been together with current partner____? How long have you been married _____?

How long have you been trying to conceive _____?

Have you ever fathered children?_____ If yes, please list dates, outcomes and current or previous partner:

_____

List dates and results of semen analyses: _____

List dates and results of hormone testing: _____

List any other surgeries/hospitalizations you had in the past (including vasectomy, reversals, varicocele):

_____

_____

List all medications or drugs you are currently taking, including over the counter medication. State how often and the reason for taking them: _____

_____

_____

Do you have trouble getting an erection?_____ Trouble maintaining an erection? _____

Do you have trouble with ejaculations? _____ If so, please explain:_____

Do you currently use tobacco products?_____ If yes, what kind and how much per day?_____

Do you drink alcoholic beverages?___ If yes, how much per day?_____

Do you use illicit drugs?____ If Yes, please explain_____

Do you have any allergies to food, medications or other. Please list:_____

Please list any personal or family history of heart disease, cancer, diabetes, Hepatis, sexually transmitted diseases, asthma, urinary problems, other:_____

_____

Referred by _____ Phone (____)_____

Nearest relative _____ Phone (____)_____

Insurance Co. _____ Name of insured _____

Address _____ Group number _____

_____ Policy number _____

Ins. Co. Phone (____)_____ ID number_____

Signature _____ Date Signed _____