Form 6

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MALE FERTILITY HISTORY FORM

Referring Physician:____
Referring Physician City, State: ____
Referring Physician Phone Number: (____)___________________________

Patient name:_________________________________DOB:__________________
Partner name: ________________________________DOB: __________________

What is the planned sperm source?
Partner: ____ Fresh sperm ____Frozen sperm ___Sperm from testicular extraction procedure
Donor: ____ Donor sperm

Has IVF been performed previously with the partner's sperm? ___ Yes ___ No
If yes, was ICSI performed? ___ Yes ___ No
If yes, what was the fertilization rate of the eggs?
____ Mature eggs inseminated ____ Eggs fertilized
____ Number of embryos that developed for transfer or preservation

What is the date of the last semen analysis? ___________
Results of last semen analysis:
Concentration: _______million/ml Progressive Motility:____% Morphology:____%

Please provide a copy of the most recent semen analysis, and of the prior IVF fertilization record if applicable.

TRM Office Use Only:

TRM Patient ID: _____________