

PATIENT INFORMATION FORM

PATIENT DETAILS

Patient Name		Date of Birth	Medical Record / ID No:
<input type="text"/>		<input type="text" value="DD / MM / YYYY"/>	<input type="text"/>
Patient Occupation	Phone No: (Optional)	Email (Optional)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Patient Address (Optional)			
<input type="text"/>			
Partner's Name		Partner's Date of Birth	Years of Infertility
<input type="text"/>		<input type="text" value="DD / MM / YYYY"/>	<input type="text"/>

PATIENT SEROLOGY REPORT

Serology Report Date	Patient Serology Status	If Positive Specify Details
<input type="text" value="DD / MM / YYYY"/>	<input type="checkbox"/> -VE <input type="checkbox"/> +VE	<input type="text"/>

SAMPLE COLLECTION DETAILS

Hospital / Centre Name	Tests	Collection Date / Time
<input type="text"/>	<input type="checkbox"/> SCSA [®] Test <input type="checkbox"/> Semen Analysis <input type="checkbox"/> _____	<input type="text" value="DD/MM/YYYY"/> <input type="text" value="HH:MM"/>
Doctor Name		Abstinence Count <input type="text" value="Days"/> <input type="text" value="M/ml"/>
<input type="text"/>		

OCCUPATIONAL EXPOSURE & LIFESTYLE HABITS

Occupation Related Exposures (If any)

Fertilizers/Pesticides
 Chemicals/Dyes
 Dust/Cement
 Paints/Solvents
 Radiation
 High Temperature

Smoking <input type="checkbox"/> Yes <input type="checkbox"/> Occasional <input type="checkbox"/> No <input type="checkbox"/> Quit _____	Alcohol Consumption <input type="checkbox"/> Yes <input type="checkbox"/> Occasional <input type="checkbox"/> No <input type="checkbox"/> Quit _____	High Caffeine Consumption <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Colas <input type="checkbox"/> Others	Others <input type="checkbox"/> Laptop Usage <input type="checkbox"/> Gym Supplements
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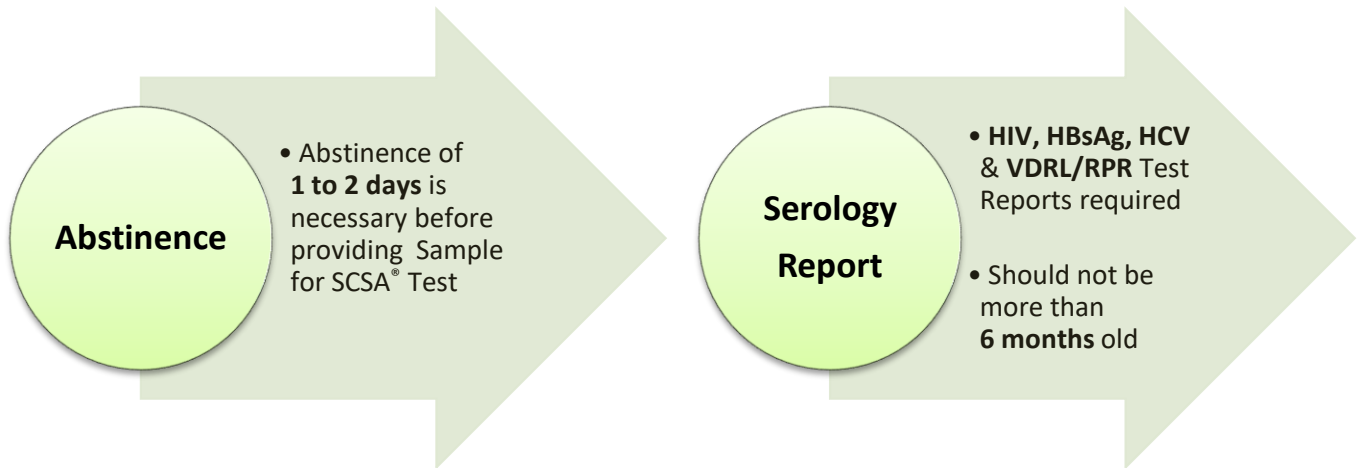
PATIENT MEDICAL HISTORY

Conditions Within Past 6 Months <input type="checkbox"/> Fever >104°F <input type="checkbox"/> Jaundice <input type="checkbox"/> Typhoid <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Mumps <input type="checkbox"/> Others _____	Existing Medical Conditions <input type="checkbox"/> Diabetes <input type="checkbox"/> BP <input type="checkbox"/> Cholesterol <input type="checkbox"/> Thyroid <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Varicocele <input type="checkbox"/> Hydrocele <input type="checkbox"/> High BMI/Obesity <input type="checkbox"/> Cancer <input type="checkbox"/> Allergy
Past Surgical History <input type="checkbox"/> Varicocelectomy <input type="checkbox"/> Hydrocelectomy <input type="checkbox"/> Circumcision <input type="checkbox"/> Undescended Testis <input type="checkbox"/> Vasectomy/Reversal <input type="checkbox"/> Penal/Testis Surgery <input type="checkbox"/> Others _____	Current Medications <input type="checkbox"/> Diabetes <input type="checkbox"/> BP <input type="checkbox"/> Cholesterol <input type="checkbox"/> Thyroid <input type="checkbox"/> Antioxidants <input type="checkbox"/> Anti-anxiety/Cortisones <input type="checkbox"/> Steroids <input type="checkbox"/> Fertility Medicines <input type="checkbox"/> Others _____

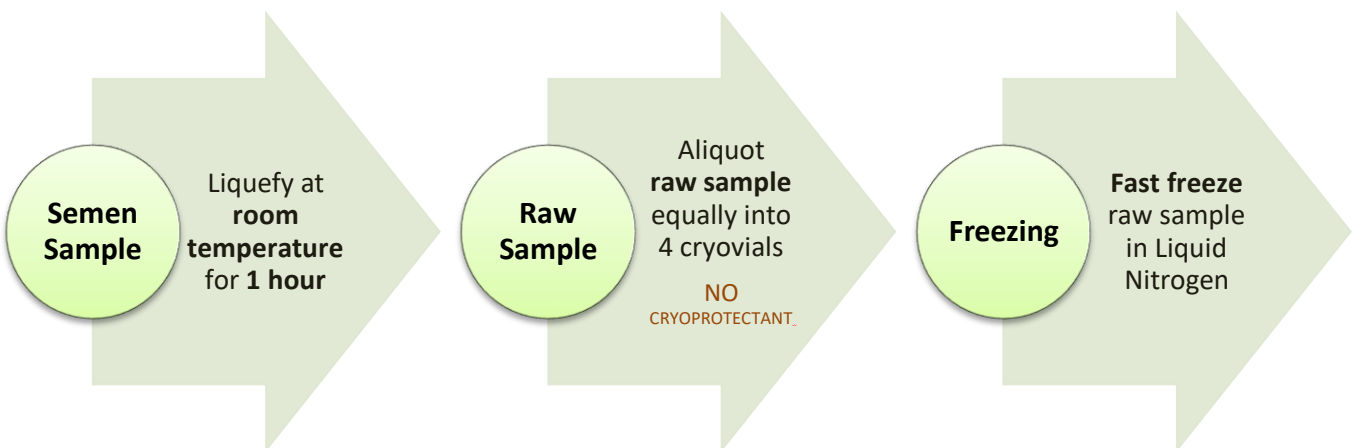
PATIENT FERTILITY HISTORY

Type of Infertility <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Male Infertility in Family <input type="checkbox"/> Father <input type="checkbox"/> Brothers <input type="checkbox"/> None	Details of the semen test have been explained to my complete satisfaction. I give my consent to Andrology Center to process my sample for testing and to also use any clinical, personally unidentifiable information, for research.
Miscarriages <input type="checkbox"/> Yes <input type="checkbox"/> No	Previous ART Treatments <input type="checkbox"/> IUI [cycles] <input type="checkbox"/> ICSI [cycles] <input type="checkbox"/> IVF [cycles] <input type="checkbox"/> TESA [cycles]	
(Signature)		

BEFORE COLLECTION



SAMPLE COLLECTION



AFTER COLLECTION

