

# Urology Associates, Ltd.

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Ngoc "Yoomie" Nguyen, PA-C

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

Dear Mr. and Mrs. \_\_\_\_\_:

The following is your infertility packet that you will need to complete and bring with you on your first visit with James A. Daitch, M.D. Your appointments are scheduled as follows:

## Semen Analysis Appointment:

Date: \_\_\_\_\_, Time: \_\_\_\_\_, Location: 202 E. Earll Dr., Suite 360  
(If you do not come in for the Semen Analysis appointment and do not call within 24 hours to reschedule, your consultation appointment will be canceled.)

*Due to the wide variability in semen collection techniques and analysis, Dr. Daitch obtains at least two and often three semen analyses on his patients. It is crucial that you abstain from ejaculation 2-3 days prior to your appointment for semen analysis, no less than 2, and no more than 5.*

## Consultation with Dr. Daitch:

Date: \_\_\_\_\_, Time: \_\_\_\_\_, Location: 202 E. Earll Dr., Suite 360  
**Please bring copies of any prior semen analyses you have had performed to your appointment or arrange to have them FAXED to 602-241-5113 Attn: Kathy.**

As discussed in our telephone conversation while scheduling your appointment, please contact your insurance company to verify that you have benefits for infertility. If your insurance company does not cover the diagnosis and or subsequent treatment of infertility, you will be responsible for payment in full at the time of your visit. The evaluation is approximately two hundred ninety two dollars (\$292.00) and the semen analysis is one hundred sixty dollars (\$160.00), there is a possibility that additional testing may be performed on this semen sample. We will bill you directly if any additional testing is done.

Please allow ninety minutes for your consultation visit with James A. Daitch, M.D. If you have any further questions, please do not hesitate to contact this office. It is important to please bring your spouse with you to your consultation appointment. Your spouse does not need to come to the semen analysis appointment but is welcome to come with you.

Infertility treatment is a team effort! We look forward to the opportunity to meet you and help you make babies!

Sincerely,

Kathy (602-264-4431 ext 2637)

202 E. Earll Drive  
Suite 360  
Phoenix, AZ 85012  
(602) 264-4431  
Fax: (602) 266-3870

# UROLOGY ASSOCIATES, LTD.

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602-264-4431

10200 N. 92nd St., Ste. 110  
Scottsdale, Arizona 85258  
480-661-2662

## Male Reproduction History and Physical

Please fill out the following form as honestly and completely as you can. The purpose of this information is to help assess your reproductive potential. All information will be held in strict confidence. (Please bring this form with you on your first visit.)

### A. IDENTIFICATION:

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

Address: \_\_\_\_\_  
\_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

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

Telephone (home): \_\_\_\_\_

(Business): \_\_\_\_\_

Referred by: \_\_\_\_\_

Relative or Friend: \_\_\_\_\_

Marital Status: (Partner's Name) \_\_\_\_\_

Single \_\_\_ Divorced \_\_\_ Married \_\_\_ Separated \_\_\_ Widowed \_\_\_

### B. FERTILITY HISTORY

1. For how many months have you been trying to achieve pregnancy with your current partner? \_\_\_\_\_

2. How old is she? \_\_\_\_\_

3. Have you achieved pregnancy with your current partner in the past?  Yes  No

4. If yes, give date and outcome of pregnancies.  
(insert letter next to corresponding number)

Pregnancy:	Pregnancy Outcome:	
#1 _____	(a) Normal Delivery	(e) Stillbirth
#2 _____	(b) Spontaneous Abortion	(f) Birth Defects
#3 _____	(c) Induced Abortion	(g) Premature Birth
#4 _____	(d) Ectopic Pregnancy	(h) Cesarean Section

5. For how many months have you used any of the following

- 5.1. Condom \_\_\_\_\_
- 5.2. Diaphragm \_\_\_\_\_
- 5.3. Foam \_\_\_\_\_
- 5.4. IUD \_\_\_\_\_
- 5.5. Pills \_\_\_\_\_
- 5.6. Rhythm \_\_\_\_\_

5.7. Have you ever undergone sterilization? \_\_\_\_\_

5.8. Has your partner ever undergone sterilization? \_\_\_\_\_

5.9. Have you been examined for infertility problems elsewhere? \_\_\_\_\_

5.10. Have you received treatment for infertility problems elsewhere? \_\_\_\_\_

5.11. Has your partner been examined for fertility problems? \_\_\_\_\_

5.12. Have you made any previous partner pregnant? \_\_\_\_\_

5.13. What was the outcome of those pregnancies?

(insert letter next to corresponding number)

Pregnancy:	Pregnancy Outcome:	
#1 _____	(a) Normal Delivery	(e) Stillbirth
#2 _____	(b) Spontaneous Abortion	(f) Birth Defects
#3 _____	(c) Induced Abortion	(g) Premature Birth
#4 _____	(d) Ectopic Pregnancy	(h) Cesarean Section

5.14. Has your current partner had any pregnancies previously with someone other than you?  Yes  No

5.15. What was the outcome of those pregnancies?

(Insert letter next to corresponding number)

Pregnancy:	Pregnancy Outcome:	
#1 _____	(a) Normal Delivery	(e) Stillbirth
#2 _____	(b) Spontaneous Abortion	(f) Birth Defects
#3 _____	(c) Induced Abortion	(g) Premature Birth
#4 _____	(d) Ectopic Pregnancy	(h) Cesarean Section

### C. SEXUAL HISTORY

1. Rate your level of sexual desire

- 1.1. Marked \_\_\_\_\_
- 1.2. Moderate \_\_\_\_\_
- 1.3. Slight \_\_\_\_\_
- 1.4. None \_\_\_\_\_

2. How many times each week do you have sexual intercourse? \_\_\_\_\_

C. SEXUAL HISTORY (cont'd)

- |   | Yes | No  |
|---|-----|-----|
| 3. Do you experience ejaculation (come) during sexual intercourse?                | ___ | ___ |
| 4. Do you ejaculate (come) into your partner's vagina?                            | ___ | ___ |
| 5. Does semen leak out of your partner's vagina after intercourse?                | ___ | ___ |
| 6. How often do you ejaculate (come)? ___ times per week                          |     |     |
| 7. How often do you masturbate? ___ times per week                                |     |     |
| 8. Do you obtain an erection easily?  | ___ | ___ |
| 9. Do you often have erections in the morning?                                    | ___ | ___ |
| 10. Are you aware of erections in the night?                                      | ___ | ___ |
| 11. Do you maintain your erection sufficiently for intercourse?                   | ___ | ___ |
| 12. Have you ever ejaculated through a flaccid (soft) penis?                      | ___ | ___ |
| 13. Do you ever ejaculate (come) prior to penetration for intercourse?            | ___ | ___ |
| 14. About how long does intercourse last before you ejaculate (come)? ___ minutes |     |     |
| 15. Is intercourse ever painful to you?   | ___ | ___ |
| 16. Is intercourse painful to your partner?                                       | ___ | ___ |
| 17. Is her vagina ever so tight that you cannot penetrate? ___                    | ___ | ___ |
| 18. Does she usually reach orgasm?  | ___ | ___ |
| 18.1 If yes, through intercourse?   | ___ | ___ |
| 18.2 Through other sexual activity?   | ___ | ___ |
| 19. Does her response in any way affect your sexual performance?                  | ___ | ___ |
| 20. Do you use any form of lubrication for intercourse?                           | ___ | ___ |
| 21. Does your partner ever swallow your semen?                                    | ___ | ___ |
| 22. Is your partner subject to vaginal infections?                                | ___ | ___ |
| 23. Does your partner douche immediately following intercourse?                   | ___ | ___ |
| 24. Rate your partner's sexual desire?  |     |     |
| 24.1. Marked _____  |     |     |
| 24.2. Moderate _____  |     |     |
| 24.3. Slight _____  |     |     |
| 24.4. None _____  |     |     |
| 25. Are your partner's menstrual periods regular?                                 | ___ | ___ |

- |   | Yes | No  |
|---|-----|-----|
| 26. Has your partner ever had any of the following illnesses? |     |     |
| 26.1. Herpes  | ___ | ___ |
| 26.2. Pelvic inflammatory disease                             | ___ | ___ |
| 26.3. Venereal disease  | ___ | ___ |
| 26.4. Gonorrhea   | ___ | ___ |
| 26.5. Non-specific urethritis                                 | ___ | ___ |
| 26.6. Syphilis  | ___ | ___ |

- |   |     |     |
|---|-----|-----|
| 27. Has your partner had abdominal surgery?                                     | ___ | ___ |
| 28. Do you have intercourse every other day during the ovulation cycle?         | ___ | ___ |
| 29. Does your partner usually get out of bed immediately following intercourse? | ___ | ___ |
| 30. Do you have a satisfactory marital adjustment?                              | ___ | ___ |

D. GENERAL MEDICAL HISTORY

Age At

- |  | Yes | No  | Diagnosis |
|--|-----|-----|-----------|
| 1. Have you ever had any of the following illnesses or conditions? |     |     |           |
| 1.1. Allergies   | ___ | ___ | _____     |
| 1.2. Arthritis   | ___ | ___ | _____     |
| 1.3. Bowel disorder  | ___ | ___ | _____     |
| 1.4. Cancer  | ___ | ___ | _____     |
| 1.5. Change in body appearance                                     | ___ | ___ | _____     |
| 1.6. Change in facial appearance                                   | ___ | ___ | _____     |
| 1.7. Color blindness   | ___ | ___ | _____     |
| 1.8. Deafness  | ___ | ___ | _____     |
| 1.9. Diabetes  | ___ | ___ | _____     |
| 1.10. Heart problems   | ___ | ___ | _____     |
| 1.11. Hepatitis  | ___ | ___ | _____     |
| 1.12. Liver disease  | ___ | ___ | _____     |
| 1.13. Lung or breathing problems                                   | ___ | ___ | _____     |
| 1.14. Thyroid disease  | ___ | ___ | _____     |
| 1.15. Generalized viral infection (i.e., mono, encephalitis)       | ___ | ___ | _____     |
| 1.16. Nervous system disease                                       | ___ | ___ | _____     |
| 1.17. Sickle cell disease  | ___ | ___ | _____     |
| 1.18. Smallpox   | ___ | ___ | _____     |
| 1.19. Influenza  | ___ | ___ | _____     |
| 1.20. Tuberculosis   | ___ | ___ | _____     |
| 1.21. Ulcers   | ___ | ___ | _____     |
| 1.22. Frequent episodes of indigestion or abdominal pain           | ___ | ___ | _____     |
| 1.23. Neck or back problems  | ___ | ___ | _____     |
| 1.24. Skin diseases  | ___ | ___ | _____     |
| 1.25. High blood pressure  | ___ | ___ | _____     |

E. UROLOGICAL HISTORY

- |   |     |     |     |
|---|-----|-----|-----|
| 1. Have you ever had infection of the prostate? | ___ | ___ | ___ |
| 1.1. of your epididymis?                        | ___ | ___ | ___ |
| 1.2. of your testicles?                         | ___ | ___ | ___ |
| 2. Kidney or bladder stones?                    | ___ | ___ | ___ |

E. UROLOGICAL HISTORY (cont'd.)

	Age At		
	Yes	No	Diagnosis
3. A venereal infection?	_____	_____	_____
4. Non-specific urethritis?	_____	_____	_____
5. Chlamydia	_____	_____	_____
6. Gonorrhea	_____	_____	_____
7. Syphilis	_____	_____	_____
8. Herpes	_____	_____	_____
9. Have you ever had a white, green, or yellow discharge from the end of your penis?	_____	_____	_____
10. Have you ever had a urinary tract infection?	_____	_____	_____
11. Have you ever had a fever in the past 3 months?	_____	_____	_____
12. Have you ever had blood in your semen?	_____	_____	_____
13. Have you ever had pain in your scrotum or testicles?	_____	_____	_____
14. Were both of your testicles descended at birth?	_____	_____	_____
15. Have you ever had any injury to your testicles or penis?	_____	_____	_____
16. Have you ever had mumps?	_____	_____	_____
16. 1. If yes, did it affect your testicles?	_____	_____	_____
17. Have you ever had an operation for:	Yes	No	Year
17.1. Hernia	_____	_____	_____
17.2. Varicocele (varicose veins in scrotum)	_____	_____	_____
17.3. Hydrocele	_____	_____	_____
17.4. Undescended testis	_____	_____	_____
17.5. Any abdominal surgery	_____	_____	_____
17.6. Operation on testicles	_____	_____	_____
17.7. Vasectomy	_____	_____	_____
17.8. Circumcision or other surgery on penis	_____	_____	_____
17.9. Other surgery	_____	_____	_____

F. ENDOCRINE HISTORY

1. Do you have or have you ever had:		
1.1. Difficulty smelling	_____	_____
1.2. Headaches	_____	_____
1.3. Visual problems	_____	_____
1.4. Enlarging hands and feet	_____	_____
1.5. Problems with perspiration and sweating	_____	_____
1.6. Changing skin color	_____	_____
1.7. Frequent episodes of lightheadedness or dizziness	_____	_____
1.8. Growth problems	_____	_____
2. Do you lack a general sense of well-being?	_____	_____
3. Do you notice a recent change in your energy level?	_____	_____

F. ENDOCRINE HISTORY (cont'd.)

	Yes	No
4. Do you have wide mood swings?	_____	_____
5. At what age did you first note armpit hair? _____		
5.1. pubic hair _____		
6. At what age did you start to shave? _____		
7. How often do you need to shave?		
#1 _____ Twice a day #2 _____ Every 2 days #3 _____ Once a day		
#4 _____ Twice a week or less #5 _____ Any change _____		
8. How does your beard compare with men of your family?		
#1 _____ Same #2 _____ Sparser #3 _____ Heavier		

G. OCCUPATIONAL HISTORY

1. What is your present occupation _____		
2. Past occupations _____		
	Yes	No
3. Is your occupation stressful?	_____	_____
4. Do you need to meet rigid deadlines or time schedules?	_____	_____
5. Do you frequently travel?	_____	_____
6. Do you have difficulty falling asleep?	_____	_____
7. Do you wake up early?	_____	_____
8. In your work or elsewhere have you been exposed to the following:		

Name (if possible)

8.1. Prolonged heat	_____	_____
8.2. Radiation	_____	_____
8.3. Pesticides	_____	_____
8.4. Agent Orange	_____	_____
8.5. Industrial solvents	_____	_____
8.6. Dyes	_____	_____
8.7. Heavy metals	_____	_____
8.8. Plastics	_____	_____

H. MEDICATIONS AND DRUGS

Are you taking or have you ever taken any of the following medications?

1. Allopurinol	_____	_____
2. Antidepressant drugs	_____	_____
3. Antihistamines	_____	_____
4. Antihypertensive drugs	_____	_____
5. Antiparasitic agents	_____	_____
6. Antipsychotic agents	_____	_____
7. Aspirin	_____	_____
8. Barbiturates	_____	_____
9. Chemotherapy for cancer	_____	_____
10. Cholestyramine	_____	_____
11. Clofibrate	_____	_____

H. MEDICATIONS AND DRUGS (cont'd.) Yes No

- 12. Digitalis \_\_\_\_\_
- 13. Dilantin \_\_\_\_\_
- 14. Diuretics \_\_\_\_\_
- 15. Hormones (estrogen, testosterone, thyroid, cortisone) \_\_\_\_\_
- 16. Immunosuppressant drugs \_\_\_\_\_
- 17. Insulin \_\_\_\_\_
- 18. Nicotinic acid \_\_\_\_\_
- 19. Norpace \_\_\_\_\_
- 20. Penicillin \_\_\_\_\_
- 21. Streptomycin \_\_\_\_\_
- 22. Sulfa drugs \_\_\_\_\_
- 23. Tagamet (Cimetidine) \_\_\_\_\_
- 24. Tetracycline \_\_\_\_\_
- 25. Tranquilizers \_\_\_\_\_

26. List your current meds: \_\_\_\_\_

27. List any nutritional supplements: \_\_\_\_\_

28. List allergies to medicines: \_\_\_\_\_

I. SOCIAL HISTORY

- |  | Yes   | No    | For how many years? |
|--|-------|-------|---------------------|
| 1. Do you smoke or chew tobacco?   | _____ | _____ | _____               |
| 1.1. Cigarettes, how many a day? _____   | _____ | _____ | _____               |
| 1.2. Marijuana cigarettes, how many a day? _____                                     | _____ | _____ | _____               |
| 1.3. Chew, how much per day? _____   | _____ | _____ | _____               |
| 2. How many alcoholic drinks do you have each day?                                   | _____ | _____ | _____               |
| 3. How many cups of coffee or caffeine-containing sodas do you drink each day? _____ | _____ | _____ | _____               |
| 4. Do you use any of the following substances:                                       | Yes   | No    |                     |
| 4.1. Cocaine   | _____ | _____ |                     |
| 4.2. LSD   | _____ | _____ |                     |
| 4.3. Amphetamines  | _____ | _____ |                     |
| 4.4. Quaalude  | _____ | _____ |                     |
| 4.5. Angel dust  | _____ | _____ |                     |
| 4.6. Heroin  | _____ | _____ |                     |
| 4.7. Methadone   | _____ | _____ |                     |
| 5. Do you take long hot baths?   | _____ | _____ |                     |

J. FAMILY HISTORY

1. Was your mother ever given diethylstilbestrol (DES)? \_\_\_\_\_

2. How many sisters do you have? \_\_\_\_\_

3. Give the number of children of each of your sisters

- 1. Sister #1 \_\_\_\_\_ 3. Sister #3 \_\_\_\_\_
- 2. Sister #2 \_\_\_\_\_ 4. Sister #4 \_\_\_\_\_

J. FAMILY HISTORY (cont'd.)

4. How many brothers do you have? \_\_\_\_\_

5. Give the number of children of each of your brothers

- 1. Brother #1 \_\_\_\_\_ 3. Brother #3 \_\_\_\_\_
- 2. Brother #2 \_\_\_\_\_ 4. Brother #4 \_\_\_\_\_

6. Are any of the following diseases or conditions present in your family:

- |                            | Yes   | No    |
|----------------------------|-------|-------|
| 6.1. Birth defects         | _____ | _____ |
| 6.2. Bowel disorders       | _____ | _____ |
| 6.3. Cancer                | _____ | _____ |
| 6.4. Cystic fibrosis       | _____ | _____ |
| 6.5. Diabetes              | _____ | _____ |
| 6.6. Extra fingers or toes | _____ | _____ |
| 6.7. Heart disease         | _____ | _____ |
| 6.8. High blood pressure   | _____ | _____ |
| 6.9. Hormone problems      | _____ | _____ |
| 6.10. Kidney disease       | _____ | _____ |
| 6.11. Lung disease         | _____ | _____ |
| 6.12. Poor sense of smell  | _____ | _____ |
| 6.13. Tuberculosis         | _____ | _____ |
| 6.14. Ulcers               | _____ | _____ |

**FOR PHYSICIAN'S USE**

PHYSICAL EXAM

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

Height in cm. \_\_\_\_\_ Weight in Kg. \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_  
Resp. \_\_\_\_\_

Span in cm. \_\_\_\_\_ Symphysis to floor in cm. \_\_\_\_\_

Symphysis to crown in cm. \_\_\_\_\_

General Appearance (NL) \_\_\_\_\_ Abnormal \_\_\_\_\_

Skin \_\_\_\_\_

Fundoscopy \_\_\_\_\_

Eyes close together \_\_\_\_\_

Head & Neck \_\_\_\_\_

Facies \_\_\_\_\_

Palate \_\_\_\_\_

Back & Spine \_\_\_\_\_

Thyroid \_\_\_\_\_

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

Extremities \_\_\_\_\_

Short 4th metacarpal \_\_\_\_\_

Short 4th metatarsal \_\_\_\_\_

Do knees touch when ankles are together?  Yes  No

HISTORY OF PRESENT ILLNESS:

NEUROLOGICAL EXAM

Hair distribution \_\_\_\_\_

Temporal\_\_\_\_ facial\_\_\_\_ pubic\_\_\_\_ axillary\_\_\_\_ chest

Fat distribution \_\_\_\_\_

Gynecomastia \_\_\_\_\_

Nipples widely spaced \_\_\_\_\_

Musculoskeletal \_\_\_\_\_

Escutcheon \_\_\_\_\_

Penis: Length \_\_\_\_\_ Foreskin \_\_\_\_\_

Scrotum Rt. Lt.

Testis volume: \_\_\_\_\_

Testis consistency: \_\_\_\_\_

Epididymis: \_\_\_\_\_

Vas deferens: \_\_\_\_\_

Varicocele: \_\_\_\_\_

Prostate: \_\_\_\_\_

Symmetry: \_\_\_\_\_

Consistency: \_\_\_\_\_

Tenderness: \_\_\_\_\_

Nodules: \_\_\_\_\_

Mass: \_\_\_\_\_

Seminal vesicles \_\_\_\_\_

U/A \_\_\_\_\_

**UROLOGY ASSOCIATES, LTD.  
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PHOENIX, ARIZONA 85012  
(602) 264-4431**

**JAMES A. DAITCH, M.D.**

**PLEASE FILL IN THE NAME AND ADDRESS OF THE DOCTOR WHO REFERRED YOU TO  
DR. DATICH.**

**NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_  
\_\_\_\_\_

**TELEPHONE NUMBER** \_\_\_\_\_