CORNELL
UNIVERSITY

NEW YORK PRESBYTERIAN
HOSPITAL

Joan and Sanford I. Weill Medical College

Marc Goldstein, M.D., F.A.C.S.
Professor of Reproductive Medicine, and Urology
Surgeon-in-Chief, Male Reproductive Medicine and Surgery

Cornell Institute for Reproductive Medicine
525 East 68th Street, Box 580, New York, NY 10021
Office: 212 746-5470 Fax: 212 746-0977
mgoldst@med.cornell.edu www.maleinfertility.org

Dear Patient,

Your appointment with Marc Goldstein, M.D., is on _______________ 20___ at ________. Our office is located at New York-Weill Cornell Medical Center, **520 East 70th Street and York Ave** ninth floor of the Starr Pavilion (Room-Starr 900), Department of Urology. You are encouraged to bring your wife or partner with you although her presence is not mandatory.

Please be sure to complete the enclosed 4 page forms and the referring physician form, before arriving for your appointment. You must obtain a copy of all your test results including semen analyses, blood hormone levels, operative report (if applicable), glass testicular biopsy slides (if applicable). Keep one copy for your records and bring one copy at the time of your appointment. **PLEASE DO NOT MAIL ANY OF THE FORMS OR RESULTS TO THE OFFICE.**

The initial consultation fee varies from $375 - $500, depending on the length and complexity of your visit with the doctor. It includes an initial interview, and complete physical examination followed by a discussion of your treatment plan. Payment is expected at the time of the visit. Dr. Goldstein is not a participating provider with any insurance company. We issue a physician's statement, which can be attached to your own insurance form for reimbursement.

***PLEASE NOTE:** Patients will be billed for those appointments not cancelled within 48 hours. We have a 24-hour answering service available. ♦**YOU MUST CALL TO CONFIRM AT LEAST 2 DAYS BEFORE YOUR SCHEDULED APPOINTMENT. IF YOU DO NOT CONFIRM, YOUR APPOINTMENT WILL BE AUTOMATICALLY CANCELLED.**♦

Thank you for your cooperation.

Center for Male Reproductive Medicine

Marc Goldstein, M.D., F.A.C.S.
Professor of Reproductive Medicine, and Urology
Surgeon-in-Chief, Male Reproductive Medicine and Surgery

Cornell Institute for Reproductive Medicine
525 East 68th Street, Box 580, New York, NY, 10021
Office: (212) 746-5470 Fax: (212) 746-0977

Center for Male Reproductive Medicine and Microsurgery

History and Examination Questionnaire

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.)

Identification:

1. Name:____

2. Address:____

____

3. Birthdate:_________________________ **4.** Age:_______________

5. Date of Appointment: _______|________|_________

6. RUH#____

7. NYH#____

8. Telephone (home)__________________________________

9. (business)____

10. Referred by:_____________________________________

11. Relative or Friend:_______________________________

12. Marital status (partner's name):_____________________

13. Single____ Divorced____ Married____ Separated____ Widowed _____

A. 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 #1_______	(a) Normal Delivery	(e) Stillbirth
Pregnancy #2_______	(b) Spontaneous Abortion	(f) Birth Defects
Pregnancy #3_______	(c) Induced Abortion	(g) Premature Birth
Pregnancy #4_______	(d) Ectopic Pregnancy	(h) Caesarean Section

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

5.1 Condom____

5.2 Diaphragm_______________________________________

5.3 Foam____

5.4 IUD____

5.5 Pills____

5.6 Rhythm____

	Yes	No
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 #1_______	(a) Normal Delivery	(e) Stillbirth
Pregnancy #2_______	(b) Spontaneous Abortion	(f) Birth Defects
Pregnancy #3_______	(c) Induced Abortion	(g) Premature Birth
Pregnancy #4_______	(d) Ectopic Pregnancy	(h) Caesarean 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 #1_______	(a) Normal Delivery	(e) Stillbirth
Pregnancy #2_______	(b) Spontaneous Abortion	(f) Birth Defects
Pregnancy #3_______	(c) Induced Abortion	(g) Premature Birth
Pregnancy #4_______	(d) Ectopic Pregnancy	(h) Caesarean 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?____________

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 to you ejaculate (come)?___________________times per week.

7. How often do you masturbate?______________________ times per week.

	Yes	No
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	____	____

	Yes	No
14. About how long does intercourse last before you ejaculate (come)? ___________ minutes		
15. Is intercourse ever painful to you?		
16. Is intercourse painful for your partner?		
17. Is her vagina ever so tight that you cannot penetrate?		
18. Does she usually reach orgasm?		
19. If yes, through intercourse?		
20. Through other sexual activity?		
21. Does her response in any way affect your sexual performance?		
22. Do you use any form of lubrication for intercourse?		
23. Do you ever ejaculate into your partner's rectum?		
24. Does your partner ever swallow your semen?		
25. Is your partner subject to vaginal infections?		
26. Does your partner douche immediately following intercourse?		

27. Rate your partner's sexual desire

27.1 Marked___________ **27.3** Slight___________

27.2 Moderate___________ **27.4** None ___________

	Yes	No
28. *Are your partner's menstrual periods regular?*		
29. *Has your partner ever had any of the following illnesses*		
29.1 *Herpes*		
29.2 *Pelvic inflammatory disease*		
29.3 *Venereal disease*		
29.4 *Gonorrhea*		
29.5 *Non-specific urethritis*		
29.6 *Syphilis*		
30. *Has your partner had abdominal surgery?*		
31. *Do you have intercourse every other day during the ovulation cycle?*		
32. *Does your partner usually get out of bed immediately following intercourse?*		
33. *Do you have a satisfactory marital adjustment?*		

D. General Medical History

1. *Have you ever had any of the following illnesses or conditions?*

	Yes	No	Age at Diagnosis
1.1 Allergies			
If yes, please specify___________			
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 (Including mitral valve prolapse)			
1.11 Hepatitis			
1.12 Liver Disease			
1.13 Lung or breathing problems			
1.14 Thyroid Disease			
1.15 Generalized viral infections (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			
If yes, please specify___________			
1.24 Skin diseases			
1.25 High blood pressure			

E. Urologic History

	Yes	No	Age at Diagnosis
1. Have you ever had infection of the prostate?			
2. of the epididymis?			
3. of your testicles?			
4. kidney or bladder stones?			
5. a venereal infection?			
6. Non-specific Urethritis?			
7. Gonorrhea?			
8. Syphilis?			
9. Herpes?			
10. Have you ever had a white, green or yellow discharge from the end of your penis?			
11. Have you ever had a urinary tract infection?			
12. Have you had a fever in the past 3 months?			
13. Have you ever had blood in your semen?			
14. Have you ever had pain in your scrotum or testicles?			
15. Were both of your testicles descended at birth?			
16. Have you ever had any injury to your testicles or penis?			
17. Have you ever had mumps?			
18. If yes, did it affect your testicles?			

19. *Have you ever had an operation for:*

	Yes	No	Year
19.1 Hernia?			
19.2 Varicocele (varicose veins in scrotum)?			
19.3 Hydrocele?			
19.4 Undescended testis?			
19.5 Any abdominal surgery?			
If yes, please specify___________			
19.6 Operation on testicles?			
19.7 Vasectomy?			
19.8 Circumcision or other surgery on penis?			
19.9 Other surgery?			
If yes, please specify___________			

F. Endocrine History

1. Do you have, or have you ever had:

	Yes	No
1.1 Difficulty smelling?		

	Yes	No
1.2 Headaches?	_____	_____
1.3 Visual problems?	_____	_____
1.4 Enlarging hands and feet?	_____	_____
1.5 Problems with perspiration/sweating?	_____	_____
1.6 Changing skin color?	_____	_____
1.7 Frequent episodes of lightheadedness or dizziness?	_____	_____
1.8 Growth problems?	_____	_____
1.9 Do you have a general sense of well-being?	_____	_____
1.10 Do you notice a recent change in your energy level?	_____	_____
1.11 Do you have wide mood swings?	_____	_____

1.12 At what age did you first note armpit hair?______________________

1.13 pubic hair?____

1.14 At what age did you start to shave?___________________________

1.15 How often do you need to shave?
1. Twice a day ! 2. Every two days ! 3. Once a day !
4. Twice a week or less ! 5. Any change__________________

1.16 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 fall asleep easily?	_____	_____
7. Do you wake up early?	_____	_____

8. *In your work or elsewhere, have you been exposed to any of 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. Medication and Drugs

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

	Yes	No
1. *Allopurinol*	_____	_____
2. *Antidepressant drugs*	_____	_____
3. *Antihistamines*	_____	_____
4. *Antihypertensive drugs*	_____	_____
5. *Antiparasite agents*	_____	_____
6. *Anti psychotic agents*	_____	_____
7. *Aspirin*	_____	_____
8. *Barbiturates*	_____	_____
9. *Chemotherapy for cancer*	_____	_____
10. *Cholestyramine*	_____	_____
11. *Clofibrate*	_____	_____
12. *Digitalis*	_____	_____
13. *Dilantin*	_____	_____
14. *Diurectics*	_____	_____
15. *Hormones (estrogen, testoserone, thyroid, cortisone)*	_____	_____
16. *Immunosuppresant drugs*	_____	_____
17. *Insulin*	_____	_____
18. *Nicotinic Acid*	_____	_____
19. *Norpace*	_____	_____
20. *Penicillin*	_____	_____
21. *Streptomycin*	_____	_____
22. *Sulfa drugs*	_____	_____
23. *Tagamet (Cimetadine)*	_____	_____
24. *Tetracycline*	_____	_____
25. *Tranquilizers*	_____	_____
26. *Propecia or Proscar*	_____	_____
27. *Alternative Medicines*	_____	_____

I. Social History

	Yes	No	For how many years?
1. Do you smoke?	_____	_____	_____
2. How many cigarettes do you smoke each day?	_____	_____	_____
3. How many marijuana cigarettes do you have each day?	_____	_____	_____
4. How many alcoholic drinks do you have each day?	_____	_____	_____

5. How many cups of coffee or caffeine-containing sodas do you drink each day?
____

6. *Do you use any of the following substances?*	Yes	No
6.1 Cocaine	____	____
6.2 LSD	____	____
6.3 Amphetamines	____	____
6.4 Quaalude	____	____
6.5 Angel Dust	____	____
6.6 Heroin	____	____
6.7 Methadone	____	____
7. Do you take long, hot baths, saunas, Jacuzzis or steam on a regular basis?	____	____

J. Family History

1. Was your mother ever given diethylstilbesterol (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 ________

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?*

6.1 Birth Defects	____	____
6.2 Bowel disorders	____	____
6.3 Cancer	____	____
6.4 Cystic fibrosis	____	____
6.5 Diabetes	____	____

	Yes	No
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

K. Physical Exam

1. Date__________________ **2.** Temp. **3.** Height in cm

4. Weight in Kg **5.** BP **6.** Pulse **7.** Resp.

8. Span in cm **9.** Symphysis to floor in cm **10.**Symphysis to crown in cm

11. General Appearance (NL) Abnormal

12. Skin____

13. Fundoscopy____

14. Eyes close together _________________________________

15. Head & Neck _______________________________________

16. Facies ____

17. Palate____

18. Back & Spine_______________________________________

19. Thyroid____

20. Heart____

21. Lungs____

22. Abdomen____

23. Extremities____

24. Short 4th metacarpel__________________________________

25. Short 4th metatarsal__________________________________

26. Do knees touch when ankles are together?

27. Neurological exam

28. Hair dist. ____

28.1 temporal____**28.2**facial____**28.3**pubic___**28.4**auxillary___**28.5**chest___

29. Fat dist. ____

30. *Gynecomastia*______________________________________

31. Nipples widely spaced_________________________________

32. Musculoskeletal ____________________________________

33. Escutcheon ____

34. Penis **34.1** length **34.2** Foreskin

35. Scrotum **R** **L**

36. Testis volume ______________________________________

37. Testis consistency___________________________________

38. Epididymis ____

39. Vas deferens_______________________________________

40. Varicocele ____

41. Prostate ____

41.1 symmetry____

41.2 consistency_______________________________________

41.2 tenderness____

41.3 nodules____

41.4 mass____

42. Seminal vesicles

43. Other ____

____

44. Diagnosis____

____

45. Plan ____

____

46. Inclusion in protocol #

47. History of Present Illness

____

____

Marc Goldstein, M.D.

CORNELL
UNIVERSITY

NEW YORK PRESBYTERIAN
HOSPITAL

Joan and Sanford I. Weill Medical College

Marc Goldstein, M.D., F.A.C.S.
Professor of Reproductive Medicine, and Urology
Surgeon-in-Chief, Male Reproductive Medicine and Surgery

Cornell Institute for Reproductive Medicine
525 East 68th Street, Box 580, New York, NY 10021
Office: 212 746-5470 Fax: 212 746-0977
mgoldst@med.cornell.edu www.maleinfertility.org

PLEASE FILL IN THE NAME AND ADDRESS OF THE DOCTOR OR RABBI WHO REFERRED YOU TO DR. GOLDSTEIN.

____
NAME

____
ADDRESS

____

____
TELEPHONE NUMBER

CORNELL
UNIVERSITY

NEW YORK PRESBYTERIAN
HOSPITAL

Joan and Sanford I. Weill Medical College

Marc Goldstein, M.D., F.A.C.S.
Professor of Reproductive Medicine, and Urology
Surgeon-in-Chief, Male Reproductive Medicine and Surgery

Cornell Institute for Reproductive Medicine
525 East 68th Street, Box 580, New York, NY 10021
Office: 212 746-5470 Fax: 212 746-0977
mgoldst@med.cornell.edu www.maleinfertility.org

PATIENT ALERT

DEAR PATIENT:

THE LABORATORY TESTS ESSENTIAL FOR A THOROUGH INFERTILITY EVALUATION ARE OFTEN QUITE COSTLY. YOU ARE RESPONSIBLE FOR KNOWING THE POLICIES AND PROCEDURES OF YOUR INSURANCE CARRIER REGARDING ALLOWABLE LABORATIES AND COVERAGE FOR ALL SERVICES.

IF YOU ARE COVERED BY PHYSICIANS HEALTH SERVICES, USE EITHER LABCORP, OR CORNING METPATH (QUEST DIAGNOSTIC) CLINICAL LABORATORIES FOR YOUR BLOOD TESTS. FAILURE TO USE THESE LABORATORIES WILL RESULT IN DENIAL OF COVERAGE FOR THESE SERVICES. PLEASE INFORM THE OFFICE PERSONNEL THAT YOU MUST USE THESE LABORATORIES AND YOU WILL BE GIVEN A PRESCRIPTION (AUTHORIZATION) TO BRING TO THE APPROPRIATE LABORATORY.

YOU MAY CALL THE TELEPHONE NUMBERS LISTED BELOW FOR A LABORATORY THAT IS CONVENIENT TO YOU:

LABCORP (NEW YORK 1-800-788-9091) (NJ 1-800-631-5250 X2642)

QUEST 1-800-225-7483 OR 1-800-222-0446