For men

Name		Date of Birth		
Address				
Telephone Number		Emergency Contact #	Cell	
			Home	
Mail Address				
Occupation				
Date of Marriage				

1	Do you have a referral today?	
2	Have you undergone fertility treatment before? If yes, please explain.	
3	Do you have any health problems currently? If yes, please explain.	
4	Have you ever experienced any abnormal side effects due to medication or shots, such as itching, rash, heart palpitations, shock, etc?	
5	Are you allergic to any medications?	
6	Have you ever contracted any of the following diseases? Hepatitis B Hepatitis C STD AIDS or HIV Leukemia None	
7	Have you ever been diagnosed with any of the following conditions? Cancer Diabetes Asthma Heart Disease High Blood Pressure Stroke None	
8	Have you ever had a blood transfusion?	
9	If you have ever had a major illness or operation, please explain in detail here.	