



Ospedale  
di Cremona

Sistema Socio Sanitario



Regione  
Lombardia  
ASST Cremona

## MEDICAL HISTORY QUESTIONNAIRE SEMEN ANALYSIS

Date \_\_\_\_\_

SURNAME \_\_\_\_\_ NAME \_\_\_\_\_

AGE \_\_\_\_\_ DAYS OF SEXUAL ABSTINENCE \_\_\_\_\_

PROFESSION \_\_\_\_\_ RESIDENCE \_\_\_\_\_

<p>Is this the first time you have undergone this test?</p> <p>YES NO <input type="checkbox"/> <input type="checkbox"/></p> <p>If not, how many other tests have you had and when?</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Did he have children? YES NO <input type="checkbox"/> <input type="checkbox"/></p>	<p>Reason for the test:</p> <p>Fertility study (*) <input type="checkbox"/></p> <p>Pre-surgical value <input type="checkbox"/></p> <p>Post-surgical value <input type="checkbox"/></p> <p>Therapeutic value <input type="checkbox"/></p> <p>Other _____ <input type="checkbox"/></p> <p><i>*For fertility treatment requests, it is advisable to contact a Reference Centre.</i></p>
<p>Are you taking any medications? YES NO <input type="checkbox"/> <input type="checkbox"/></p> <p>What kind of drugs?</p> <p>Anti-inflammatories <input type="checkbox"/></p> <p>Antibiotics <input type="checkbox"/></p> <p>Antiparasitics <input type="checkbox"/></p> <p>Antifungals <input type="checkbox"/></p> <p>Corticosteroids <input type="checkbox"/></p> <p>Diuretics <input type="checkbox"/></p> <p>Antidepressants <input type="checkbox"/></p> <p>Antihypertensives <input type="checkbox"/></p> <p>Antiarrhythmics <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>	<p>Do you suffer or have suffered from:</p> <p>Mumps (Age____) <input type="checkbox"/></p> <p>Typhoid <input type="checkbox"/></p> <p>Liver diseases <input type="checkbox"/></p> <p>Diabetes <input type="checkbox"/></p> <p>Hypertension <input type="checkbox"/></p> <p>Prostate disease <input type="checkbox"/></p> <p>Varicocele <input type="checkbox"/></p> <p>Genitourinary infections <input type="checkbox"/></p> <p>Fever (last 6 months) <input type="checkbox"/></p> <p>Other _____ <input type="checkbox"/></p>	<p><b>FOR LABORATORY USE ONLY</b></p> <p>The patient states that he consumes:</p> <p>Alcohol <input type="checkbox"/></p> <p>Tobacco <input type="checkbox"/></p> <p>Drugs <input type="checkbox"/></p> <p><i>He underwent a series of magnetotherapy sessions on</i> _____/_____/_____/_____</p>
<p>Trade Name</p> <p>_____</p>	<p><b>SPERM COLLECTION</b></p> <p><input type="checkbox"/> Complete</p> <p><input type="checkbox"/> Partial</p>	<p><b>NOTE</b></p> <p>_____</p> <p>_____</p> <p>_____</p>

The DOCTOR \_\_\_\_\_