THE ZOLL CENTER

MALE FERTILITY FORM

Stuart Zoll DOM, FABORM 7301 West Palmetto Park Road Suite 103 C Boca Raton Florida, 33433
Call Central Scheduling 561-395-2667 TheZollCenter.com FB: The Zoll Center

Date	First Name	Last Name	Middle Initial
_____ / _____ / _____			

Gender	Date of Birth	Age	Body Type	Height:	Weight:	Complexion:	Occupation
M F	_____ / _____ / _____						

Name of your doctor/ Fertility Specialist: RMFC / CCRM / FCC / Conceptions / CU

Other OBGYN doctor _____ Start Date: _____ Month/ Year

Western Diagnosis _____

1. **Results for Sperm Analysis:**

Date	Count	Morphology	Motility	Volume

2. Do we have a copy of your Semen Analysis? Y / N

3. Other Procedures/ Date:

Varicocele	Vasectomy	Vasectomy Reversal	SCSA / ASA	Others

4. Do you take any of these Supplements and/or Vitamins?

# of Months on Vitamins	Male Vitamins	Prenatal	Fish Oil	L - Carnitine	L - Arginine	Antioxidants	ZC Complete List

Other: _____

5. Couples ART Plans:

IUI	Clomid	IVF	PGD	TESA	Other

6. Has the patient father children Y / N **If so, how many _____**

7. Male Health

Infection	Chlamydia,	Erectile Dysfunction	Ejaculation Problems	Retrograde Ejaculation	Prostate
	Y / N	Y / N	Y / N	Y / N	Y / N

8. Male Health Continued

Antisperm Antibodies	Sperm Chromatid / DNA Integrity	High Cholesterol	Diabetes (fasting, glucose)	Others
Y / N	Y / N	Y / N	Y / N	

9. Is you Spouse currently being treated by us? Y / N

Spouse's Name _____

Western Diagnosis of Spouse _____