PATIENT INFORMATION FORM

Lab ID #_____

Patient Name (last) _____ (first) _____

Date of Birth ____ ____ / ____ ____ / ____ ____

Social Security Number ____ ____ ____ ____ ____ ____ ____ ____ ____

Partner's Name (last) _____ (first) _____

Partner's Date of Birth ____ ____ / ____ ____ / ____ ____

Physician Ordering Test: Dr._____

Patient History:
List any medications you are currently taking or have completed within the past Two weeks:

_____

_____

_____

Have you had a fever during the past month? [ ] yes [ ] no
Have you used a Hot Tub or Sauna during the past month? [ ] yes [ ] no
Date of most recent ejaculation, prior to the sample collected today _____

Sample Collection:
Method of collection [ ] masturbation [ ] other If checked "other" list method
_____

Did you lose any portion of the ejaculate? [ ] No
[ ] Yes, first portion
[ ] Yes, middle portion
[ ] Yes, last portion