WashU Medicine

Reproductive Medicine
Partner Supplement Form
Sperm-Producing Partner Information

Demographics

Partner's Full Name: _____

Date of Birth: _____

Patient Name (individual being seen by provider): _____

Patient Date of Birth: _____

Patient Phone Number: _____

Insurance Information: Required for potential testing (Semen Analysis)

Insurance Company Name: _____

Group Number: _____

Member ID: _____

Claim Phone Number: _____

Health History

History of STD/if yes, please list infections: _____

Surgical History/list relevant surgeries: _____

Have you ever caused a pregnancy? YES_____NO_____

Have you ever had a semen analysis? YES_____NO_____

If so, when was the last one and what were the results?_____

Drug Use: _____

Do you take testosterone or anything that boosts testosterone? _____

Do you use lubricants during sexual intimacy? YES_____NO_____

Please list any Medications you are taking:_____

Please list any medical conditions you have:_____

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