Male Infertility Questionnaire

Name____ Age _________
LAST FIRST MI

Date of Birth _____/_____/_____ SS# ______-________-_____

Name of partner____ Partner's Date of Birth _____/_____/_____

Current Urologist (if seeing one) ____ Phone ___________________

Address ____

Current Primary Care Physician____ Phone____________________

Address ____

Number of pregnancies conceived with current partner… ……… _____________

Number of pregnancies conceived with previous partners……… _____________

Please list dates and outcomes of any pregnancies conceived with a previous partner:

Date	**Pregnancy outcome**: *Normal or Cesarean delivery? Termination or miscarriage? Tubal or ectopic pregnancy?*	**Infertility treatment if any?**	**# of months required to conceive?**	**Comments or complications?**

			comments
Do you have any difficulties with your erection ? …………	Yes	No	___________________
Do you have any difficulties with ejaculation? …………....	Yes	No	___________________
Have you had any serious injuries to your genitals? …	Yes	No	___________________
Have you had any infections of your penis, testicles, prostate? …	Yes	No	___________________
Have you been diagnosed with a varicocele? ……………	Yes	No	___________________
Have you had any other problems with your genitals? …..	Yes	No	___________________

Have you ever had a semen analysis (sperm count) performed? Please list results if able.

Date	**Physician/Location**	**Count (million/ml)**	**Motility**	**Morphology**

Male Infertility Questionnaire

Please list all previous surgeries:

Date	Location	Procedure	Findings	Surgeon

Medical problems:

Problem	Yes or No?	Currently active?	In the past?	Comments
Have you ever had a problem with headaches or migraines?	**Y / N**			
Have you ever had a problem with your heart or heart valves (heart murmur)?	**Y / N**			
Have you ever had any lung problems (such as asthma or cystic fibrosis)?	**Y / N**			
Have you ever had any stomach or bowel problem (such as ulcer or inflammation of the bowel)?	**Y / N**			
Have you had any muscle or joint problems?	**Y / N**			
Have you had any neurologic disorders?	**Y / N**			
Have you ever been treated for depression or anxiety?	**Y / N**			
Have you ever had a hormonal problem (such as thyroid disease or diabetes)?	**Y / N**			
Have you had any immune diseases? (such as Lupus, or immune arthritis)?	**Y / N**			

Do you have any other medical problems, unrelated to your fertility?

____

____

Do you have any allergies to medications? Please list medication and reaction.

____

____

Do you take medications regularly? Please list medication and dosage. Include vitamins and herbal supplements.

Male Infertility Questionnaire

Family and Genetic History

What is your ethnic background? *(optional)* ________________________________

What is your religion? *(optional)* ________________________________

These questions help us screen for potential genetic problems based on your background.

Is there a family history of having or carrying cystic fibrosis ? … Yes No ________________________

Is there a family history of Tay-Sachs disease? ………………... Yes No ________________________

Is there a family history of having or carrying Sickle-cell anemia? Yes No _________________________

Is there a family history of thalassemia or other blood disorder? Yes No _________________________

Is there a family history of pregnancy loss? ………………………. Yes No _________________________

Does anyone in the family have a child with birth defects

or mental retardation? ……………………………………. Yes No _________________________

Are there any other diseases in the family you would like to tell us about ?

Social history

Do you smoke cigarettes? ………………………………………….. Yes No

If yes, cigarettes per day_____________ Would you like assistance in quitting smoking? __________

Do you drink alcohol? ………………………………………………. Yes No

If yes, drinks per day______ drinks per week__________

Do you smoke marijuana? ……………………………………………Yes No

If yes, times per week _____________ Would you like assistance in quitting? __________

Do you use any other recreational drugs? ……………………… Yes No

If yes, would you like assistance in quitting? ____

Do you have any chemical exposures at work you are concerned about? ______________________________

Patient Signature____ Date ___________________

Office use only:

Physician Review____ Date ___________________

Interim history ____

____Date_____________________

____

____Date_____________________

____

____Date_____________________