

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: <i>Normal or Cesarean delivery? Termination or miscarriage? Tubal or ectopic pregnancy?</i>	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 _____

