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Male Reproductive Health Center
Questionnaire

To provide you with the best possible care, I would appreciate it greatly if you could fill out the following questionnaire concerning your health. There is also a section for your partner to complete concerning her health. All of the information will be held in strict confidence as it becomes a part of your medical chart. Please bring this with you when you see me for your first visit.

Your Name: _____ Date ____/_____/_____

Home Tel. #: (___) _____

Work/Day # (___) _____ Your age: _____

Partner's Full Name:_____ Partner's age: _____

REFERRING DOCTOR(S):

Yours: Dr._____ And Dr._____

_____ _____

_____ _____

_____ _____

Tel: _____ Tel:_____

Partner's Doctor:

Dr._____

_____

_____

_____

Tel:_____

QUESTIONS FOR HIM (Fill in the blank or circle word):

1. If married, number of years _____
2. How many years trying to conceive? _____
3. Prior pregnancies between you and your partner? (number) _____
    3a. Number of pregnancies carried to term and delivered _____
    3b. Number of miscarriages _____
    3c. Number of planned abortions _____
4. Number of pregnancies between you and another partner _____
    4a. Number of pregnancies carried to term and delivered _____
    4b. Number of miscarriages _____
    4c. Number of planned abortions _____
5. Method of birth control, if used in past _____
    5a. How many times each week (on average) do you have intercourse? _____
6. Type of lubricant, if used_____
7. Have you had prior infertility treatments? Yes No
8. Do any of the following concern you?
    8a. Your ability to get an erection Yes No
    8b. Your ability to maintain an erection Yes No
    8c. Ejaculating before your partner is ready Yes No

MEDICAL HISTORY

9. Have you ever been told (or know) that you have any of the following?

9a.	Undescended testicles at birth?	Yes	No
9b.	If you had undescended testes, which side(s)?	L__	R___
9c.	Mumps after puberty with painful testes?	Yes	No
9d.	Diabetes mellitus	Yes	No
9e.	Cancer	Yes	No
9f.	Multiple sclerosis	Yes	No
9g.	Other neurological problems	Yes	No
9h.	Cystic Fibrosis	Yes	No
9i.	Sickle cell anemia	Yes	No
9k.	Infection of the urine	Yes	No
9l.	Infection of the prostate (prostatitis)	Yes	No
9m.	Infection of the epididymis (epididymititis)	Yes	No
9n.	Veneral disease	Yes	No
9o.	Green or yellow discharge from the penis	Yes	No
9p.	Blood in your ejaculate	Yes	No
9q.	Bothered by problems with urination	Yes	No
9r.	Injury to the testicles that needed hospitalization	Yes	No
9s.	Ulcers	Yes	No
9t.	Kidney stones	Yes	No
9u.	Pain in your scrotum or testes	Yes	No
9v.	Lots of problems with bronchitis or pneumonias	Yes	No
9w.	Any other medical problems (list below)	Yes	No

_____

_____

SURGICAL HISTORY

10. Have you ever been told or remember any of the following?

10a.	A hernia operation?	Yes	No
10b.	If you had a hernia operation, which side(s)?	L__	R___
10c.	Any bladder or penis operation as a child?	Yes	No
10d.	Pelvic or back surgery	Yes	No
10e.	Testis surgery	Yes	No
10f.	Surgery for varicoceles	Yes	No
10g.	Surgery for hydroceles	Yes	No
10h.	Surgery for scrotal cysts	Yes	No
10i.	Vasectomy	Yes	No
10j.	Any other surgery in the past (list below)	Yes	No

_____

_____

_____

EXPOSURE HISTORY

11a. Please list the medications (doses too) that you take below:

_____
_____
_____
_____

11b. Do you smoke cigarettes (or cigars or pipes)? Yes No
11c. If/when you smoke(d), how long did you smoke? (years) _____
11d. If/when you smoke(d), how many cigs/cigars per day? _____
11e. If you quit smoking, how long has it been (years)? _____
11f. Do you use any of the following (circle one response)?

Alcohol	None	<2 drinks/day	>2 drinks/ day
Coffee	None	<2 cups/day	>2 cups/day
Soda	None	<2 cans/day	>2 cans/day
Marijuana	None	Infrequent	Frequent

11g. What do you do for work?_____
11h. Do you travel alot for work? Yes No
11i. Do you consider your job stressful? Yes No
11j. If stressful, can you rate it? Low
Moderate
High
Extreme
11k. Any radiation or harmful chemicals on the job? Yes No
11L If yes to above, please list the exposure and when?

Agent	Year
_____	_____
_____	_____
_____	_____

11m. Any exposure to prolonged heat in work/hobbies? Yes No
11n. Any pesticide exposure? Yes No
11o. Do you use hot tubs, saunas or jacuzzi's? Yes No
How often? (circle one)
Every day
Every other day
Once a week
Occasionally

ENDOCRINE HISTORY/REVIEW OF SYSTEMS

12. Do you have (or have you ever had) any of the following?

12a. Difficulty with smell? Yes No

12b. Difficulty with vision (besides needing glasses)? Yes No

12c. Changing skin color (not tanning related)? Yes No

12d. Problems with growth when you were young? Yes No

12e. Did your voice change later than your friends'? Yes No

12f. How often do you need to shave?
_____Once a day
_____Once every other day
_____Twice a week or less

12g. Has your shaving pattern changed recently? Yes No

12h. Any tenderness to your breasts? Yes No

12i. Fevers in the last 3 months Yes No

FAMILY HISTORY

13. Concerning the rest of your family:

13a. How many brothers do you have? _____

13b. How many sisters do you have? _____

13c. Have any of your brothers or sisters had troubling having children? Yes No

13d. Are their any adopted children in your family Yes No
If so, who has adopted children? _____

13e. Any miscarriages in the immediate family? Yes No

13f. Did your mother ever take DES (diethylstilbesterol)? Yes No

13g. Did your parents have troubling conceiving you or your brothers or sisters? Yes No

QUESTIONS FOR HER (Fill in the blank or circle the word):

14. Is this your first marriage? Yes No
15. Number of pregnancies between you and another partner _____
    4a. Number of pregnancies carried to term and delivered _____
    4b. Number of miscarriages _____
    4c. Number of planned abortions _____
16. Do you have any medical problems? Yes No

    If so, please list them: _____

    _____

    _____

    _____

17. Have you been evaluated for infertility in the past? Yes No
18. Do you have regular menstrual cycles? Yes No
19. Which of the following tests do you remember having done?

	Yes	No	Can't Remember	Result
Basal Body Temps	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Blood tests	_____	_____	_____	_____
Post-coital test	_____	_____	_____	_____
Hysterosalpingogram	_____	_____	_____	_____
Laparoscopy	_____	_____	_____	_____

20. Which of the following treatments have you had to date?

	Yes	No	When?
Clomid	_____	_____	_____
IUI	_____	_____	_____
IVF	_____	_____	_____
IVF/ICSI	_____	_____	_____
GIFT	_____	_____	_____

Thank you very much for filling out this questionnaire.