Patient Label

Fertility Questionnaire

In order to assess your fertility and to give you the best medical treatment possible, we would appreciate your completion of this questionnaire. There is also a section for your partner to complete as well. All information will be held in strict confidence. Please bring this completed questionnaire with you on your first visit.

Please bring with you any records (semen analyses, doctor's notes, etc) pertaining to prior fertility evaluations.

If you do not have a spouse/partner or are not currently trying to establish a pregnancy, simply omit the irrelevant questions.

Patient (Male)

Day time phone________________________________ Evening phone ____________________________________

Do we have your permission to communicate our findings with your partner's/wife's gynecologist to facilitate the establishment of a pregnancy? ☐ Yes ☐ No ☐ Not Applicable

Years married/years with partner: _________________ Years trying to conceive: _______________

Previous birth control method with current partner: ____

Previous pregnancies with spouse/partner:

Live births (0-9) ______ Miscarriages (0-9) ______ Abortions (0-9) ______

Previous pregnancies with someone other than your spouse or partner:

Live births (0-9) ______ Miscarriages (0-9) ______ Abortions (0-9) ______

Spouse / Partner Information

Name: ____ Birth date: ____/____/____ Age: ________

Previous pregnancies with any other partners (not including spouse/current partner :)

Live births (0-9) ________ Miscarriages (0-9) ________ Abortions (0-9) ________

List any history of medical/gynecological problems (e.g. pelvic or vaginal infections, fibroids, and endometriosis):

____

Do you have regular menstrual cycles/periods? ☐ Yes ☐ No

Have you been evaluated for infertility? ☐ Yes ☐ No

If yes, physician's name and address: ____

____

❖ ***Tests performed:***

Ultrasound ☐ Normal ☐ Abnormal ☐ Not done

Hysterosalpingogram (“dye test”)	☐ Normal	☐ Abnormal	☐ Not done
Laparoscopy	☐ Normal	☐ Abnormal	☐ Not done
Hormone levels	☐ Normal	☐ Abnormal	☐ Not done
Postcoital test	☐ Normal	☐ Abnormal	☐ Not done
Other: ___________________	☐ Normal	☐ Abnormal	☐ Not done

Please list any treatment for infertility and dates (i.e., Clomid, Pergonal, IVF, GnRH, HCG injections, Progesterone, intrauterine inseminations,): ____

____

____

Sexual History

On average, how frequently do you have intercourse? _______ times per month

How often do you have intercourse around the time of your wife’s/partner’s ovulation?
☐ Daily ☐ Every other day ☐ Less than every other day ☐ Ovulation unpredictable

On average, how often do you masturbate? _______ times per month

Do you have any problems getting or maintaining an erection? ☐ Yes ☐ No
If yes, please specify: ____

Do you have any problems with ejaculation? ☐ Yes ☐ No
If yes, please specify: ____

Do you use any form of lubrication for intercourse? ☐ Yes ☐ No
If yes, what kind: ____

Is intercourse ever painful for you or your partner? ☐ Yes ☐ No
If yes, please specify: ____

Have you noticed any change in your sexual desire or drive? ☐ Yes ☐ No
If yes, please specify: ____

Fertility History

❖ ***Do you presently have or have you ever had any of the following:***

Did you have undescended testicles at birth? ☐ Yes ☐ No If yes, Right ___ Left ___ Bilateral ___
(some boys are born with their testicles in their abdomen)

Have you ever had a hernia operation? ☐ Yes ☐ No If yes, Right ___ Left ___ Bilateral ___

Approximately at what age did you start going through puberty? _________________

At what age did you start to shave? _______________

How often do you shave now? ___________________

Have you ever had the mumps? ☐ Yes ☐ No Did you have the mumps after puberty? ☐ Yes ☐ No

❖ ***Have you ever had any of the following?***

Diabetes (sugar)	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Neurological disorders (e.g. Multiple Sclerosis)	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No
Bladder or pelvic surgery	☐ Yes	☐ No

Have you ever had a urinary tract infection? ☐ Yes ☐ No

Have you ever had a prostate infection? ☐ Yes ☐ No

Have you ever had an infection in the testicles or epididymis? ☐ Yes ☐ No

Have you ever had blood in your ejaculate (semen)? ☐ Yes ☐ No

Have you ever had a venereal disease? ☐ Yes ☐ No

Have you ever had white, green or yellow discharge from the end of your penis? ☐ Yes ☐ No

- ***Have you ever had surgery for:***

  Vasectomy? ☐ Yes ☐ No

  Varicocelectomy (tying off dilated veins to the scrotum)? ☐ Yes ☐ No

  Testicular or scrotal surgery? ☐ Yes ☐ No

  Penis surgery? ☐ Yes ☐ No

Have you ever had trauma (injury) to your testicles? ☐ Yes ☐ No
If yes, please specify: ____

____

Do you have any problems with urination (i.e. reduced flow, urgency, etc.) If so, please describe: ____________

____

Have you ever taken steroids? ☐ Yes ☐ No

Have you ever taken testosterone supplements? ☐ Yes ☐ No

Have you ever had any chemotherapy? ☐ Yes ☐ No

Have you ever had radiation therapy or been exposed to radiation (other than routine x-rays)? ☐ Yes ☐ No

Do you frequently take hot baths, saunas, or steam baths, Or are you exposed to temperature extremes (hot or cold)? ☐ Yes ☐ No

Have you ever been exposed to chemicals, solvents and their fumes, or any toxins/poisons (e.g., pesticides)? ☐Yes ☐ No

Do you frequently get colds, upper respiratory tract infections or sinus infections? ☐ Yes ☐ No

Have you had a fever or viral illness within the past year? ☐ Yes ☐ No
If yes, when? ________________________________

Do you have significant problems with your sense of smell? ☐ Yes ☐ No

Have you noticed any problems with your peripheral vision? ☐ Yes ☐ No

Have you noticed any secretions or tenderness in your breasts? ☐ Yes ☐ No

Are you overly sensitive to heat or cold? ☐ Yes ☐ No

Do you have any testicular pain or discomfort? ☐ Yes ☐ No

Have you had any prior evaluations for infertility? If so, please describe:____________________________

____

____

Family Fertility History

Do you think any of your relatives had trouble conceiving? ☐ Yes ☐ No ☐ Unknown
If yes, please explain why you think so (indicate the relative): ______________________________

____

Are you adopted? ☐ Yes ☐ No ☐ Unknown

How many brothers do you have? __________ Do they have children? ☐ Yes ☐ No

What year(s) were your brothers born? ______________________________

How many sisters do you have? __________ Do they have children? ☐ Yes ☐ No

What year(s) were your sisters born? ______________________________

Are any of your brothers or sisters adopted? ☐ Yes ☐ No ☐ Unknown
If yes, please specify which ones: ______________________________

Do you think any of your siblings (brothers or sisters) had trouble conceiving? ☐ Yes ☐ No ☐ Unknown
If yes, please explain why you think so (include which sibling(s) and any known medical causes):

____

____

Are there any known miscarriages in your family or relatives: ☐ Yes ☐ No ☐ Unknown
If yes, please specify: ______________________________

____

Are there any medical (i.e. heart disease, cancer, diabetes) or genetic diseases, which run in your family? If so, please describe:

Relative	Disease/Disorder
____________________	____________________
____________________	____________________

Past Medical History

Are you having problems (now or in the past) with any of the following? ☐ No ☐ Yes If yes, please check all boxes that apply.

Anemia	☐	Kidney Stones	☐
Arthritis	☐	Liver Disease	☐
Asthma	☐	Mitral Valve Prolapse	☐
Cancer	☐	Osteoporosis	☐
Type of cancer: ____________		Rheumatic Fever	☐
Depression	☐	Thyroid Problems	☐
Diabetes	☐	Toxic Exposure	☐
GERD / Acid Reflux	☐	Tuberculosis	☐
Gout (high uric acid)	☐	Other/Explain: ____________	
Heart Disease	☐		
High Blood Pressure	☐	____________	
High Cholesterol	☐		
		____________	

Past Surgical History

Have you had **surgery** on any of the following? ☐ No ☐ Yes If yes, please check all boxes that apply.
INCLUDE THE SURGERY DATE:

Appendix	☐	Prostate	☐
Back	☐	Testicle	☐

Bladder ☐
Breast ☐
Colon ☐
Gallbladder ☐
Heart Bypass ☐
Heart Valve ☐
Hernia ☐
Incontinence ☐
Kidney ☐
Lung ☐

Thyroid ☐
Total Joint Replacement ☐
Right: ☐ Hip ☐ Knee ☐ Shoulder
Left: ☐ Hip ☐ Knee ☐ Shoulder
Knee ☐
Urethra ☐
Vasectomy ☐
Other/Explain: ______________________________

____

Allergies

Do you have any allergies? ☐ Yes ☐ No If yes, please list the allergy and type of reaction: ____________

____

____

____

Latex allergy? ☐Yes ☐ No Have you ever had MRSA? ☐Yes ☐ No Positive Mantoux/PPD? ☐Yes ☐ No

Medications

Are you taking Aspirin, Coumadin, blood thinners? ☐ Yes ☐ No

Please list any <u>prescription medications</u> you currently or frequently take: ______________________________

____

____

____

____

Please list any <u>over-the-counter medications – including herbal therapies</u> you currently or frequently take:

____

____

____

Social History

Do you or did you ever smoke? ☐ Yes ☐ No If yes, how long (yrs) _________ Number of packs/day _________

When did you quit smoking? _______________

❖ ***Do you now or have you ever used any of the following drugs?***

Caffeine ☐ Yes ☐ No Amount ______________________ Frequency ____________________

Alcohol ☐ Yes ☐ No Amount ______________________ Frequency ____________________

Marijuana ☐ Yes ☐ No Amount ______________________ Frequency ____________________

Others ☐ Yes ☐ No Amount ______________________ Frequency ____________________

Are you employed? ☐ Yes ☐ No ☐ Retired

Occupation: ______________________________

Partner's occupation: ______________________________

Review of Systems

Do you have any problems related to the following systems? Please circle No or Yes.

Constitutional Symptoms			***Eyes***			***Neurological***		
Fever	No	Yes	Blurred vision	No	Yes	Tremors	No	Yes
Chills	No	Yes	Double vision	No	Yes	Dizzy spells	No	Yes
Headache	No	Yes	Pain	No	Yes	Numbness/tingling	No	Yes
Other___________	No	Yes	Other______________	No	Yes	Other____________	No	Yes

Endocrine			***Gastrointestinal***			***Cardiovascular***		
Excessive thirst	No	Yes	Abdominal pain	No	Yes	Chest pain	No	Yes
Too hot/cold	No	Yes	Nausea/vomiting	No	Yes	Varicose veins	No	Yes
Tired/sluggish	No	Yes	Indigestion/heartburn	No	Yes	High blood pressure	No	Yes
Other___________	No	Yes	Other______________	No	Yes	Other____________	No	Yes

Integumentary			***Musculoskeletal***			***Ear/Nose/Throat/Mouth***		
Skin rash	No	Yes	Joint pain	No	Yes	Ear infection	No	Yes
Boils	No	Yes	Neck pain	No	Yes	Sore throat	No	Yes
Persistent itch	No	Yes	Back pain	No	Yes	Sinus problems	No	Yes
Other___________	No	Yes	Other______________	No	Yes	Other___________	No	Yes

Allergic/Immunologic			***Hematologic/Lymphatic***			***Respiratory***		
Hay fever	No	Yes	Swollen glands	No	Yes	Wheezing	No	Yes
Drug allergies	No	Yes	Blood clotting problem	No	Yes	Frequent cough	No	Yes
Other___________	No	Yes	Other______________	No	Yes	Shortness of breath	No	Yes
						Other___________	No	Yes

Genitourinary			***Psychologic***		
Urine retention	No	Yes	Are you generally satisfied with your life?	No	Yes
Painful urination	No	Yes	Do you feel severely depressed?	No	Yes
Urinary frequency	No	Yes	Have you ever considered suicide?	No	Yes
Other__________	No	Yes	Other______________________________	No	Yes

HOW DID YOU HEAR ABOUT US? ☐ Physician ☐ Relative ☐ Friend ☐ Newspaper ad ☐ Magazine ad ☐ Yellow pages ☐ Website ☐ Seminar ☐ Radio/television ☐ Other: ______________________________

Physician use only: (Comments)

PHYSICIAN SIGNATURE: ____________________________________ DATE: ____________________