



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? If yes, please specify: _____ Yes No
 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

Arthritis

Asthma

Cancer

Type of cancer: _____

Depression

Diabetes

GERD / Acid Reflux

Gout (high uric acid)

Heart Disease

High Blood Pressure

High Cholesterol

Kidney Stones

Liver Disease

Mitral Valve Prolapse

Osteoporosis

Rheumatic Fever

Thyroid Problems

Toxic Exposure

Tuberculosis

Other/Explain: _____

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

Back

Prostate

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 prescription medications you currently or frequently take: _____

Please list any over-the-counter medications – including herbal therapies 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount _____	Frequency _____
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount _____	Frequency _____
Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount _____	Frequency _____
Others	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Fever No Yes
 Chills No Yes
 Headache No Yes
 Other _____ No Yes

Eyes

Blurred vision No Yes
 Double vision No Yes
 Pain No Yes
 Other _____ No Yes

Neurological

Tremors No Yes
 Dizzy spells No Yes
 Numbness/tingling No Yes
 Other _____: No Yes

Endocrine

Excessive thirst No Yes
 Too hot/cold No Yes
 Tired/sluggish No Yes
 Other _____ No Yes

Gastrointestinal

Abdominal pain No Yes
 Nausea/vomiting No Yes
 Indigestion/heartburn No Yes
 Other _____ No Yes

Cardiovascular

Chest pain No Yes
 Varicose veins No Yes
 High blood pressure No Yes
 Other _____ No Yes

Integumentary

Skin rash No Yes
 Boils No Yes
 Persistent itch No Yes
 Other _____ No Yes

Musculoskeletal

Joint pain No Yes
 Neck pain No Yes
 Back pain No Yes
 Other _____ No Yes

Ear/Nose/Throat/Mouth

Ear infection No Yes
 Sore throat No Yes
 Sinus problems No Yes
 Other _____ No Yes

Allergic/Immunologic

Hay fever No Yes
 Drug allergies No Yes
 Other _____ No Yes

Hematologic/Lymphatic

Swollen glands No Yes
 Blood clotting problem No Yes
 Other _____ No Yes

Respiratory

Wheezing No Yes
 Frequent cough No Yes
 Shortness of breath No Yes
 Other _____ No Yes

Genitourinary

Urine retention No Yes
 Painful urination No Yes
 Urinary frequency No Yes
 Other _____ No Yes

Psychologic

Are you generally satisfied with your life? No Yes
 Do you feel severely depressed? No Yes
 Have you ever considered suicide? 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: _____