

## Male Fertility Questionnaire

**Instructions:** Please complete **ALL PAGES** of this questionnaire as completely as possible. All information is confidential. In addition to this questionnaire, you should have the following test results forwarded to our office:  
1. Results of 2 (two) separate semen analysis performed within the last 3 months  
2. Minimum blood tests: follicle stimulating hormone (FSH), testosterone and prolactin drawn *before 930 am*

### SPOUSAL INFORMATION

Partners name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Partners birthday: \_\_\_\_\_ Age \_\_\_\_\_ Married/together since (year): \_\_\_\_\_

When did you start attempting to achieve a pregnancy (Month/Year)? \_\_\_\_\_

Have you seen another urologist for fertility problems?  Yes  No If YES, name: \_\_\_\_\_

Name(s) of your partner's physicians: Family MD \_\_\_\_\_ Gynecologist \_\_\_\_\_

Is it OK if we copy your information to you partner's physicians in order to facilitate her care?  Yes  No

### PRIOR PREGNANCIES (including miscarriages and terminations).

Have you had a pregnancy with your **current** partner?  Yes  No If yes, please give date/outcome of pregnancy

\_\_\_\_\_  
\_\_\_\_\_

Have you had a pregnancy with any **previous** partners?  Yes  No If yes, please give date/outcome of pregnancy

\_\_\_\_\_  
\_\_\_\_\_

Has your partner had a pregnancy with **previous** partner?  Yes  No If yes, please give date/outcome of pregnancy

\_\_\_\_\_  
\_\_\_\_\_

What forms of contraception have you used with your current partner (check all that apply):

Condoms  Pills  IUD  Rhythm method  Diaphragm

Thinking back over the past 6 months, approximately how many times per week are you having intercourse? \_\_\_\_\_

Are you timing intercourse to ovulation?  Yes  No If YES, how are you timing intercourse?

Basal body temperature  Counting days from the onset of menstruation  
 Change in cervical mucus  Urine ovulation kit

Please indicate the number of siblings you have. Brothers \_\_\_\_\_ Sisters \_\_\_\_\_

Do any of your siblings have a history of difficulty achieving a pregnancy?  Yes  No If yes, provide details

Do any members of your family have any of the following conditions? Please check:

Birth defects  Cystic fibrosis  Diabetes  Hormone problems

Do you have sperm banked (cryopreserved) anywhere? Yes  No  If YES, indicate where: \_\_\_\_\_

**PLEASE COMPLETE ALL PAGES**

## Male Fertility Questionnaire

Mark [X] the correct column after each question. If YES to any of the below questions, please explain.

	Yes	No	Not Sure		Yes	No	Not Sure
Do you currently have or do you have a history of:				Do you take or have you taken in the past:			
1. Fever > 38C (101 °F) in the past 6 months				30. Anabolic steroids for bodybuilding			
2. Regular use of a hot tub, sauna or hot bath				31. Allopurinol			
3. Use lubricants for intercourse				32. Antidepressants/antipsychotics			
4. Problems with erections *				33. Antihypertensives			
5. Problems with ejaculation				34. Antiparasitic agents			
6. Blood in your ejaculate/semen				35. Barbituates			
7. Blood in your urine				36. Cimetidine			
8. Vasectomy				37. Chemotherapy for cancer			
9. Vasectomy reversal				38. Cholesterol lowering drugs			
10. Varicocele repair				39. Clomid (clomiphene)			
11. Testicular torsion				40. Dilantin			
12. Surgery for undescended testes				41. Hormones			
13. Other types of scrotal surgery				42. Immunosuppressant drugs			
14. Inguinal/hernia surgery (which side?)				43. Insulin			
15. Difficulty with urination *				44. Prostate medications			
16. Difficulty with bowel movements				45. Ranitidine			
17. Problem with your vision (not incl. glasses)				46. Any exposure at work to toxic chemicals			
18. Problems with your sense of smell				47. Radiation treatment			
19. How many alcoholic drinks per week?				Have you and your partner undergone any of the following treatments: If yes, enter the number of times for each			
20. Tobacco smoking. How much?				48. Undergone prior assisted reproductive treatments? If so, check below:			
21. Marijuana smoking				49. Hormonal treatment			
22. Any other 'street drugs'				50. Intrauterine insemination			
Do you have a history of infection of the urinary or genital tract?:				51. In vitro fertilization (IVF)			
23. Bladder infection (cystitis)				52. Had a scrotal ultrasound			
24. Prostate infection (prostatitis)				Has your PARTNER had:			
25. Testis infection (orchitis)				53. A sexually transmitted infection			
26. Mumps after the onset of puberty				54. Pelvic inflammatory disease			
27. Gonorrhea				55. Endometriosis			
28. Chlamydia				56. Uterine fibroids			
29. Herpes				57. Any abdominal or pelvic surgery			
30. Other: indicate below				58. A hysterosalpingogram			
Do you take or have you taken in the past:				59. Her hormones checked			
31. Acyclovir				60. Irregular periods/menstruation			

\* If you have problems with erections, complete IIEF form; if problems with urination, complete IPSS form

Is there anything else that you want us to know about you or which you think might affect your ability to have children?

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**PLEASE COMPLETE ALL PAGES**