Infertility Questionnaire for Men

General Information

Name ____ Date ____________________

Address ____

____

Telephone ____________________________ Home _________________________ Work __________________________Cell

Birth date _____________________ Age________________ Social Security No. ______________________________________

Occupation ____

Ethnic Background ______________________________________

Height ____________________ Weight__________________

Highest Education______________________________________

Partner's Name _______________________________________

Married ☐ Yes ☐ No

Referred by: ________________________________

Infertility History

Have you ever fathered a pregnancy? ______ yes ______ no

If yes, when (year of birth) ________________________

Have you ever been told you are infertile? _____ yes _____ no

If yes, when and by whom?_______________________________

Length of time attempting pregnancy _____Years _____Months

Length of time not using contraceptives ___________________

Have you ever been treated for: Dates

- Syphilis __________
- Gonorrhea __________
- Chlamydia (non-specific urethritis) __________
- Prostatitis (infection of the prostate) __________
- Infection of the testicles __________
- Infection of the seminal vesicles __________

Do you have a history of genital herpes ______Yes ______No

Sexual History

Has there been any change in your libido or sexual drive? ____ yes ____ no

Is there any difficulty in maintaining an erection? ____ yes ____ no

Do you ejaculate into the vagina without difficulty? ____ yes ____ no

Do you have any pain or burning with urination or ejaculation ___ yes ___ no

Have you ever had any discharge from the penis? ____ yes ____ no

Frequency of sexual intercourse per week? _________

Medical/Surgery History	Yes	No	Dates/Comments
Elevated Blood pressure	_____	_____	____________________
Heart murmur	_____	_____	____________________
Heart disease	_____	_____	____________________
Diabetes	_____	_____	____________________
Lung disease	_____	_____	____________________
Liver or gall bladder disease	_____	_____	____________________
Jaundice	_____	_____	____________________
Kidney infections	_____	_____	____________________
Hepatitis	_____	_____	____________________
Kidney stones	_____	_____	____________________
Gout	_____	_____	____________________
Urinary tract abnormalities	_____	_____	____________________
Thyroid disease	_____	_____	____________________
Arthritis	_____	_____	____________________
Auto immune diseases (lupus, rheumatoid arthritis, etc.)	_____	_____	____________________

Other serious or chronic diseases ____

Any surgery (list type and year) ____

Do you have any allergies (medications, food, latex): Yes _______ No _______

If yes, list the specific allergies and reactions experienced: ______________________________

____

Please list any medications you are now taking or have taken in the past. Current: __________________ __________________ Past: __________________ __________________

Are you currently taking a testosterone supplement or have you taken one in the past? Current: __________________ __________________ Past: __________________ __________________

Any history of therapeutic x-ray treatment or anti-cancer drugs? Current: __________________ __________________ __________________ Past: __________________ __________________ __________________

Have you ever been involved in psychotherapy or counseling? Yes _______ No_______

If yes, please indicate why, when, with whom, and any other pertinent information. ______________________________

Please fill in a review of any current or recent symptoms:

	Yes	No		Yes	No		Yes	No
Chronic headaches	____	____	Increased thirst	____	____	Fatigue	____	____
History of head injury	____	____	Increased sweating	____	____	Tremors	____	____
Convulsion history	____	____	Intolerance to heat	____	____	Desire for extra salt	____	____
Visual problems	____	____	Intolerance to cold	____	____	Rapid weight change	____	____
Dizziness	____	____	Difficulty sleeping	____	____	Change of appetite	____	____

Please include any other information which you believe may be pertinent to your infertility problem ______________________________

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Occupation/Leisure History

	Yes	No	Dates/Comments
Have you ever been employed in an occupation with sustained high temperature?	_____	_____	____________
Do you use hot tubs, saunas, etc.?	_____	_____	____________
Exposed to chemicals or x-rays in work or hobby	_____	_____	____________
Please list			**Amount per day or week**
Caffeine	_____	_____	____________
Smoking	_____	_____	____________
Alcohol	_____	_____	____________
Marijuana	_____	_____	____________
Drugs (not prescribed), list	_____	_____	____________

Please describe recreational/sports activities, exercise (frequency, length of time, etc.)____________________

____

Family History

Father's age if alive ______ If no longer living, cause of death ____________________

Medical problems: ____________________

Mother's age if alive ______ If no longer living, cause of death ____________________

Medical problems: ____________________

Sister(s) ages ________ medical problems:____________________

Brother(s) ages ________ medical problems: ____________________

Is there a family history of:	Yes	No	Comments
Birth defects or genetic diseases	_____	_____	____________
Mental Retardation	_____	_____	____________
Infertility	_____	_____	____________
Hormone problems	_____	_____	____________
Miscarriages/stillbirths	_____	_____	____________
Pregnancy problems	_____	_____	____________
Cancer	_____	_____	____________
Stroke	_____	_____	____________
Heart disease	_____	_____	____________
Lung disease	_____	_____	____________
Diabetes	_____	_____	____________
Thyroid/endocrine problems	_____	_____	____________
High blood pressure	_____	_____	____________
Any women who have never menstruated	_____	_____	____________
Any men who have never had to shave	_____	_____	____________

Any additional comments you would like to make that you feel may be pertinent and have not already been addressed:

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____

Previous Infertility Testing

Previous urological exam? ☐ yes ☐ no

Name of donor and results:____

Previous semen analysis? ☐ yes ☐ no

Results	Date	Count (million/cc)	Motility (% moving)	Morphology (% normal shape)
	_______	_______________	________________	_______________
	_______	_______________	________________	_______________
	_______	_______________	________________	_______________
	_______	_______________	________________	_______________

Specialized sperm testing? ☐ yes ☐ no
(Acrosome reaction, sperm penetrating assay,
antibody testing)

Results (which tests): ____

Specific treatment for Male Infertility? ☐ yes ☐ no

Details: ____