Heartland Center for Reproductive Medicine

# Fertility Partner Questionnaire

## General Information

Legal Name_____ Preferred First Name_____ Date _____

Pronouns: he/him/his ____ she/her/hers ____ they/them/their ____ zie/hir ____ other _____

Gender Identity: (cis)female ____ (cis)male ____ transmale ____ transfemale ____ nonbinary ____ other _____

Sexual Orientation _____ Sex Assigned at Birth _____ Birthdate _____

Age _____ Occupation _____ Employer _____ SSN _____

Address _____

Phone # _____ Height _____ Weight _____ Ethnic Background _____

Partners Name_____ Married ☐ Yes ☐ No Who lives in the home with you?_____

Who referred you? _____ Self Referred: ☐

Reason for appointment today? _____

## Male Partner History *(complete if applicable)*

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 _____ 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

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 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? _____

Circle previous use of: diaphragm condom foam rhythm sponge other_____

## 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: _____

## Name:

### Female Partner History *(complete if applicable)*

**Are you interested in carrying a pregnancy or using your eggs to have a biological child? _____ yes _____ no _____unsure**
**If you answered no, you do not need to complete the rest of this section - please skip to Occupational/Leisure History**

Age of first period _____. Date of first day of last period _____. Usual cycle length _____days _____ range (interval from start of one period to start of next). Usual duration of bleeding _____ days

Do you have any symptoms at time of ovulation (i.e., pain)? _____ yes _____ no

Amount of flow ___ Light ___ Moderate ___ Heavy. Is cramping ___ None ___Minimal ___ Moderate ___ Severe

Bleeding between periods? ___ Never ___Sometimes ___ Always. Do you skip periods? ___ Never ___ Sometimes ___ Always

Circle symptoms preceding period: None Breast soreness Irritability.

History of: Pelvic Pain _____

Last PAP _____ Mammogram _____

| | | Dates Treated |
|---|---|---|
| Have you ever been treated for: | Syphilis _____yes _____no | _____ |
| | Gonorrhea _____yes _____no | _____ |
| | Chlamydia _____yes _____no | _____ |
| | Genital Warts _____yes _____no | _____ |

Do you have a history of genital herpes _____ yes _____ no. Did your mother take any medications while pregnant with you? _____ yes _____ no _____don't know _____ What? Was DES taken _____ yes _____ no

Have you been pregnant before? ___ yes ___ no. Do you have children: ___ yes ___ no _____ ages

How long to conceive: _____

| RECORD ALL PREGNANCIES | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Year | Full term | Preterm | Miscarriage | Terminations | Complications | Fertility Treatment |
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |

Have you ever undergone fertility testing or treatment? ____Yes ____No ____Unsure

If yes, please describe:_____

_____

_____

_____

_____

## Name:

| 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) _____

_____

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. _____

_____

## Allergies

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

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

_____

## Medications

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

_____ _____

_____ _____

Are you currently taking a testosterone supplement or Current: _____ Past: _____

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** _____

_____

## Name:

| 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 / age _____

Medical problems: _____

Mother's age if alive _____ If no longer living, cause of death / age _____

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:**

_____

_____

_____

_____