



### MALE REPRODUCTIVE HEALTH QUESTIONNAIRE

To provide you with the best possible care, please fill out the following questionnaire concerning your health. There is also a section for your partner to complete concerning her health. All information will be held in strict confidence, as it becomes a part of your medical chart.

First Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Partner's full Name: \_\_\_\_\_ Partner's date of Birth: \_\_\_\_\_  
 Preferred contact:     Email     US Mail     Phone:     work     home

#### Referring Physician(s):

##### Yours:

Full Name: _____	Full Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____	Phone: _____

##### Hers:

Full Name: _____	Full Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____	Phone: _____

*Please bring any pertinent lab results (such as hormones or ultrasounds) to your appointment.*

#### Questions for HIM

1. Married or committed relationship?  No  
 Yes - Number of years: \_\_\_\_\_
2. How many times each week (on average) do you have intercourse? \_\_\_\_\_
3. How many years trying to conceive? \_\_\_\_\_

4. Prior pregnancies between you and your partner?  No  
 Yes - Number of pregnancies carried to term and delivered: \_\_\_\_\_  
Number of miscarriages: \_\_\_\_\_  
Number of planned abortions: \_\_\_\_\_
4. Prior pregnancies between you and another partner?  No  
 Yes - Number of pregnancies carried to term and delivered: \_\_\_\_\_  
Number of miscarriages: \_\_\_\_\_  
Number of planned abortions: \_\_\_\_\_
5. Have you used birth control in past?  No  
 Yes - Type/method(s) used: \_\_\_\_\_
6. Have you used lubricant?  No  
 Yes - Type(s) used: \_\_\_\_\_
7. Have you had prior infertility treatments?  No  
 Yes - Type/method(s) used: \_\_\_\_\_
8. Do any of the following concern you:
- ...your ability to get an erection?  No  
 Yes - Comment (if any): \_\_\_\_\_
- ...your ability to maintain an erection?  No  
 Yes - Comment (if any): \_\_\_\_\_
- ...ejaculating before your partner is ready?  No  
 Yes - Comment (if any): \_\_\_\_\_

## MEDICAL HISTORY

Have you ever been told (or know) that you have any of the following:

1. Undescended testicles at birth?  No  
 Yes - Which side (left or right): \_\_\_\_\_
2. Mumps after puberty with painful testes?  No  
 Yes - Comment (if any): \_\_\_\_\_
3. Cancer?  No  
 Yes - Type/treatment: \_\_\_\_\_
4. Multiple sclerosis?  No  
 Yes - Comment (if any): \_\_\_\_\_
5. Other neurological problems?  No  
 Yes - Type/treatment: \_\_\_\_\_
6. Infection of the urinary tract?  No  
 Yes - Type/treatment: \_\_\_\_\_
7. Infection of the prostate (prostatitis)?  No  
 Yes - Comment (if any): \_\_\_\_\_
8. Infection of the epididymis (epididymitis)?  No  
 Yes - Comment (if any): \_\_\_\_\_
9. Venereal disease?  No  
 Yes - Type/treatment: \_\_\_\_\_
10. Green or yellow discharge from the penis?  No  
 Yes - Type/treatment: \_\_\_\_\_
11. Blood in your ejaculate?  No  
 Yes - Comment (if any): \_\_\_\_\_
12. Bothered by problems with urination?  No  
 Yes - Type/treatment: \_\_\_\_\_

13. Injury to the testicles that needed hospitalization?  No  
 Yes - Type/treatment: \_\_\_\_\_
14. Ulcers?  No  
 Yes - Type/treatment: \_\_\_\_\_
15. Kidney stones?  No  
 Yes - Type/treatment: \_\_\_\_\_
16. Pain in your scrotum or testes?  No  
 Yes - Type/treatment: \_\_\_\_\_
17. Problems with bronchitis or pneumonias?  No  
 Yes - Type/treatment: \_\_\_\_\_
18. Any other medical problems (list below)?  No  
 Yes - Type/treatment: \_\_\_\_\_  
Type/treatment: \_\_\_\_\_  
Type/treatment: \_\_\_\_\_
19. Do you have **allergies or reactions** to medications you've taken?  No  
 Yes - Medication: \_\_\_\_\_  
Medication: \_\_\_\_\_  
Medication: \_\_\_\_\_

## SURGICAL HISTORY

Have you ever been told (or know) that you have had any of the following:

1. A hernia operation?  No  
 Yes - Date/year (if known): \_\_\_\_\_
2. If you had a hernia operation?  No  
 Yes - Date/year (if known & which side): \_\_\_\_\_
3. Bladder or penis operation as a child?  No  
 Yes - Date/year (if known): \_\_\_\_\_
4. Pelvic or back surgery?  No  
 Yes - Date/year (if known): \_\_\_\_\_
5. Testis surgery?  No  
 Yes - Date/year (if known): \_\_\_\_\_
6. Surgery for varicoceles?  No  
 Yes - Date/year (if known): \_\_\_\_\_
7. Surgery for hydroceles?  No  
 Yes - Date/year (if known): \_\_\_\_\_
8. Surgery for scrotal cysts?  No  
 Yes - Date/year (if known): \_\_\_\_\_
9. Vasectomy?  No  
 Yes - Date/year (if known): \_\_\_\_\_
10. Other infertility surgery?  No  
 Yes - TURED - Date/year (if known): \_\_\_\_\_  
 Yes - Sperm - Aspiration Date/year (if known): \_\_\_\_\_  
 Yes - Vasectomy reversal - Date/year (if known): \_\_\_\_\_

- Yes - Epididymovasostomy - Date/year (if known): \_\_\_\_\_
- Yes - Electroejaculation - Date/year (if known): \_\_\_\_\_
11. Any other surgery in the past (list below)?  No
- Yes - Type/treatment: \_\_\_\_\_
- Type/treatment: \_\_\_\_\_
- Type/treatment: \_\_\_\_\_

## EXPOSURE HISTORY

1. Do you take any medications?  No
- Yes - Medication/dose: \_\_\_\_\_
- Medication/dose: \_\_\_\_\_
- Medication/dose: \_\_\_\_\_
2. Do you currently smoke?  No
- Yes -  cigarettes  cigars  pipe:
- how many years: \_\_\_\_\_
- how often (per day): \_\_\_\_\_
3. If you quit smoking, how long has it been?:  # of months \_\_\_\_\_  # of years \_\_\_\_\_
4. Do you use any of the following:
- ...alcohol?  No
- Yes -  less than 2 drinks/day  more than 2 drinks/ day
- ...coffee?  No
- Yes -  less than 2 cups/day  more than 2 cups/day
- ...soda?  No
- Yes -  less than 2 cans/day  more than 2 cans/day
- ...marijuana?  No
- Yes -  Infrequently  Frequently
5. What is your occupation? \_\_\_\_\_
6. Do you travel a lot for work?  No
- Yes -  Infrequently  Frequently
7. Do you consider your job stressful?  No
- Yes -  Low stress  Moderately stressful
- High stress  Extremely stressful
8. Are there any radiation or harmful chemical(s) used on the job?  No
- Yes - Type/length of exposure: \_\_\_\_\_
- Type/length of exposure: \_\_\_\_\_
- Type/length of exposure: \_\_\_\_\_
9. Any exposure to prolonged heat in work/hobbies?  No
- Yes - Type/length of exposure: \_\_\_\_\_
10. Any pesticide exposure?  No
- Yes - Type/length of exposure: \_\_\_\_\_

11. Do you use hot tubs, saunas or jacuzzis?  No
- Yes -  Every day  Every other day
- Once a week  Occasionally

## ENDOCRINE HISTORY/REVIEW OF SYSTEMS

Have you ever been told (or know) that you have any of the following:

1. Difficulty with smell?  No  
 Yes - Comment (if any): \_\_\_\_\_
2. Difficulty with vision (besides needing glasses)?  No  
 Yes - Comment (if any): \_\_\_\_\_
3. Changing skin color (not tanning related)?  No  
 Yes - Comment (if any): \_\_\_\_\_
4. Problems with growth when you were young?  No  
 Yes - Comment (if any): \_\_\_\_\_
5. Did your voice change later than your friends?  No  
 Yes - Comment (if any): \_\_\_\_\_
6. Do you need to shave?  No  
 Yes -  Every day  Every other day  
 Once a week  Twice a week or less
7. Has your shaving pattern changed recently?  No  
 Yes - Comment (if any): \_\_\_\_\_
8. Any tenderness to your breasts?  No  
 Yes - Comment (if any): \_\_\_\_\_
9. Fevers in the last 3 months?  No  
 Yes - Comment (if any): \_\_\_\_\_

## FAMILY HISTORY

Concerning the rest of your family:

1. Do you have any blood related brothers?  No  
 Yes - How many: \_\_\_\_\_
2. Do you have any blood related sisters?  No  
 Yes - How many: \_\_\_\_\_
3. Has any of your brothers or sisters had troubling having children?  No  
 Yes - Who: \_\_\_\_\_  
Cause/problem (if known): \_\_\_\_\_
4. Are there any adopted children in your family?  No  
 Yes - Who: \_\_\_\_\_
5. Any miscarriages in the immediate family?  No  
 Yes - Comment (if any): \_\_\_\_\_
6. Did your mother ever take DES (diethylstilbesterol)?  No  
 Yes - Comment (if any): \_\_\_\_\_
7. Did your parents have problems conceiving you or your brothers or sisters? ?  No  
 Yes - Comment (if any): \_\_\_\_\_

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## QUESTIONS FOR HER:

1. Do you have any blood related brothers?  No  
 Yes - How many: \_\_\_\_\_
2. Do you have any blood related sisters?  No

- Yes - How many: \_\_\_\_\_
3. Has any of your brothers or sisters had troubling having children?  No
- Yes - Who: \_\_\_\_\_
- Cause/problem (if known): \_\_\_\_\_
4. Are there any adopted children in your family?  No
- Yes - Who: \_\_\_\_\_
5. Any miscarriages in the immediate family?  No
- Yes - Comment (if any): \_\_\_\_\_
6. Is this your first marriage?  No
- Yes - Comment (if any): \_\_\_\_\_
7. Prior pregnancies between you and another partner?  No
- Yes - Number of pregnancies carried to term and delivered: \_\_\_\_\_
- Number of miscarriages: \_\_\_\_\_
- Number of planned abortions: \_\_\_\_\_
8. Any other medical problems (list below)?  No
- Yes - Type/treatment: \_\_\_\_\_
- Type/treatment: \_\_\_\_\_
- Type/treatment: \_\_\_\_\_
9. Have you been evaluated for infertility in the past?  No
- Yes - Comment (if any): \_\_\_\_\_
10. Do you have regular menstrual cycles?  No
- Yes - Comment (if any): \_\_\_\_\_
11. Which of the following tests do you remember having done:
- ... basal body temps?  Can't remember  No
- Yes -  Result: \_\_\_\_\_
- ... ultrasound?  Can't remember  No
- Yes -  Result: \_\_\_\_\_
- ... blood tests?  Can't remember  No
- Yes -  Result: \_\_\_\_\_
- ... post-coital test?  Can't remember  No
- Yes -  Result: \_\_\_\_\_
- ... hysterosalpingogram?  Can't remember  No
- Yes -  Result: \_\_\_\_\_
- ... laparoscopy?  Can't remember  No
- Yes -  Result: \_\_\_\_\_
12. Which of the following treatments have you had to date:
- ... Clomid?  Can't remember  No
- Yes -  When: \_\_\_\_\_
- ... IUI?  Can't remember  No
- Yes -  Result: \_\_\_\_\_
- ... IVF?  Can't remember  No
- Yes -  Result: \_\_\_\_\_
- ... IVF/ICSI?  Can't remember  No
- Yes -  Result: \_\_\_\_\_

... GIFT?

Can't remember

No

Yes -  Result: \_\_\_\_\_

Thank you both for filling out this questionnaire.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Patient Label

\_\_\_\_\_  
Partner Signature

\_\_\_\_\_  
Date