SHADY GROVE FERTILITY
REPRODUCTIVE SCIENCE CENTER

Questionnaire for Men

General Information

Name _____ Date _____
Address _____
_____
Telephone _____ Home _____ Work _____ Cell
Birth date _____ Age _____
Occupation _____
Ethnic Background _____
Height _____ Weight _____
Highest Education _____

Wife's Name _____
Marriage date _____

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 _____

Did your mother take DES or other medications while pregnant with you?
_____ yes _____ no _____ don't know
If yes, list: _____
_____
_____

_____

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
Mumps	_____	_____	_____
Measles	_____	_____	_____
Chicken Pox	_____	_____	_____
Rubella (German Measles)	_____	_____	_____
Rheumatic fever	_____	_____	_____
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 to medications: Yes _____ No _____

If yes, which medications. _____

_____

_____ _____

Please list any medications you are now taking or have taken 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 _____

_____

_____

Occupation/Leisure History	Yes	No	Dates/Comments
Have you ever been employed in an occupation with sustained high temperature?	_____	_____	_____
Do you drive long distances as part of your employment?	_____	_____	_____
Do you use hot tubs, saunas, etc.?	_____	_____	_____
Exposed to chemical 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 (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	_____	_____	_____
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:

_____

_____

Pre-conceptual Health Screening

Have you ever been tested for:	**Yes**	**No**	**If yes, give dates/results**
Hepatitis B	☐	☐	_____
HIV (AIDS)	☐	☐	_____
Rubella	☐	☐	_____
TB (Tuberculosis)	☐	☐	_____
Blood Type	☐	☐	_____
Tay-Sachs	☐	☐	_____
Gaucher Disease	☐	☐	_____
Canavan Disease	☐	☐	_____
Cystic Fibrosis	☐	☐	_____
Sickle cell	☐	☐	_____
Diabetes	☐	☐	_____
Thallasemia	☐	☐	_____

Previous Infertility Testing

Previous urological exam? ☐ yes ☐ no

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: _____