



Reproductive Endocrinology & Fertility Male Patient Questionnaire

Please answer the questions to the best of your ability. Leave blank any questions to which you do not know the answer. If you are uncomfortable with any question, you may leave it blank.

IDENTIFYING INFORMATION

Date of initial appointment: _____ SSN: _____

Name: _____ Partner's Name: _____

Address: _____

Telephone Number – Day: _____ Evening: _____

Current Age: _____ Date of Birth: _____ Height: _____ Weight: _____ Partner's Date of Birth: _____

E-mail address: _____

Have you heard of PAMFOnline: Yes No Are you registered with them: Yes No

Would you like more information on it? Yes No

EMPLOYMENT

Please describe all current employment including job title, description of responsibilities, duration of employment

FERTILITY EVALUATION

1. How long have you and your partner been attempting to achieve pregnancy? _____

2. Have you ever been responsible for any pregnancy in the past? Yes No
If so, please indicate Same partner Different partner

FERTILITY STUDIES

1. Have you ever had any of the following tests? (Check all that apply).

- | | |
|--|--|
| <input type="checkbox"/> Semen analysis | <input type="checkbox"/> Chromosome test |
| <input type="checkbox"/> Chlamydia test | <input type="checkbox"/> Hamster egg penetration test |
| <input type="checkbox"/> Mycoplasma/Ureaplasma culture | <input type="checkbox"/> Hormonal tests (FSH, LH, prolactin, testosterone) |
| <input type="checkbox"/> Testicular biopsy | <input type="checkbox"/> X-ray or ultrasound of testis |

2. Have you ever provided a specimen for an intrauterine insemination for your partner? Yes No

If yes, when? _____

3. Have you ever had any surgery involving any part of the reproductive tract? (Check all that apply).

- | | |
|--|--|
| <input type="checkbox"/> Varicocele repair | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Vasectomy reversal | <input type="checkbox"/> Repair of obstruction of vas deferens |
| <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Testicular torsion repair | <input type="checkbox"/> Removal of testis |
| <input type="checkbox"/> Testicular biopsy | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Sperm aspiration | |

4. Have you ever had any significant testicular injury? Yes No

If yes, please describe _____

5. Have you ever taken any of the medications listed below

- | | |
|---|--|
| <input type="checkbox"/> clomiphene citrate | <input type="checkbox"/> hCG (Profasi, Pregnyl) |
| <input type="checkbox"/> injectable gonadotrophins | <input type="checkbox"/> testosterone or male hormones |
| <input type="checkbox"/> anabolic steroids | <input type="checkbox"/> prednisone |
| <input type="checkbox"/> bromocriptine (Parlodel or Dostinex) | <input type="checkbox"/> other (specify) _____ |

6. How frequently do you and your partner have intercourse? _____ per week/month.

7. Have you experienced any difficulties with intercourse that you believe may be contributing to infertility? Yes No

If yes, please explain _____

8. Do you have or have you ever had any of the following (Check all that apply).

- | | |
|---|---|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Human Papilloma Virus or genital warts |
| <input type="checkbox"/> gonorrhoea | <input type="checkbox"/> mumps with testicular involvement |
| <input type="checkbox"/> nongonococcal urethritis | <input type="checkbox"/> prostatitis |
| <input type="checkbox"/> herpes | <input type="checkbox"/> syphilis |

REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas? Circle YES or NO below. If YES, please give explanation.

		Patient Comments:	Physician Comments
Constitutional (good general health lately)	YES/NO		
Eyes	YES/NO		
Ears/Nose/Mouth/Throat	YES/NO		
Cardiovascular (heart/blood vessels/circulation)	YES/NO		
Gastrointestinal (stomach/intestines)	YES/NO		
Genitourinary (genitals/sexual functions/kidney/bladder)	YES/NO		
Neurological (brain/nervous system)	YES/NO		
Integumentary (skin areas and/or breasts)	YES/NO		
Psychiatric (emotions/mood/memory)	YES/NO		
Musculoskeletal (bones/joints/muscles)	YES/NO		
Endocrine (hormones/metabolism/thyroid)	YES/NO		
Allergic/immunological (allergies/immune system)	YES/NO		
Hematologic/Lymphatic (blood or bleeding problems; lymph nodes or "swollen glands")	YES/NO		

PAST MEDICAL HISTORY

Do you have or have you ever had (check all that apply):

- Anemia
- Appendicitis
- Arthritis
- Breast disease
- Blood transfusion
- Chronic bronchitis
- Chronic headaches
- Cancer? (Specify _____

- Diabetes
- Dizziness
- Gallbladder disease
- Heart disease
- Hepatitis
- High blood pressure
- Kidney problems
- Liver problems
- Loss of balance
- Measles: German
- Mumps with testes involved
- Neurological problems
- Pneumonia
- Rheumatic fever
- Scarlet fever
- Seizures
- Testicular tumor
- Tuberculosis
- Vision problems
- Other: _____

PAST SURGICAL HISTORY

Have you ever had any surgeries in the past? Yes No

If yes, please indicate date, type, findings of surgery below

MEDICATIONS

Are you allergic to any medications? Yes No If yes, please indicate name of medication and type of reaction it causes below

<u>Medications</u>	<u>Reaction</u>
_____	_____
_____	_____

Are you currently taking any prescription medications? Yes No If yes, please indicate below

<u>Medications</u>	<u>Reason</u>
_____	_____
_____	_____

Are you currently taking any over-the-counter medications? Yes No If yes, please indicate below

<u>Medications</u>	<u>Reason</u>
_____	_____
_____	_____

SOCIAL HISTORY

Are you currently married/domestic partner? _____ If so, how long? _____

Have you previously been married? _____

Do you smoke? _____ If so, how many packs per day? _____

Do you drink alcohol? _____ If so, how many alcoholic beverages per week? _____

Do you use illicit (illegal) drugs? _____ If so, please list _____

Do you exercise regularly? _____ If so, please indicate type of exercise and estimate hrs/week spent in this activity.

<u>Type</u>	<u>Hours/week</u>	<u>Type</u>	<u>Hours/week</u>
_____	_____	_____	_____
_____	_____	_____	_____

Have you had a significant weight change in the last year? Yes No

If yes, please indicate weight gain _____ lbs weight loss _____ lbs

Do you follow a particular food diet? Yes No

vegetarian diet plan name _____ other _____

FAMILY HISTORY

Have any of these illnesses occurred in your family? Check all that apply and indicate relationship to you:

<u>Illness</u>	<u>Relationship to you</u>
<input type="checkbox"/> diabetes	_____
<input type="checkbox"/> high blood pressure	_____
<input type="checkbox"/> heart disease	_____
<input type="checkbox"/> breast cancer	_____
<input type="checkbox"/> ovarian cancer	_____
<input type="checkbox"/> colon cancer	_____
<input type="checkbox"/> prostate cancer	_____
<input type="checkbox"/> other	_____

Form completed by _____ Relationship to patient _____
(please print) (write self if you are the patient)