PIONEER VALLEY
UROLOGY, P.C.

Name: ______________________ Date: ______________________

Date of Birth: _____/_______/_____Age:_____

Male Infertility Questionnaire

Chief Complaint (Why do you want to see the doctor today?):

____

____

Partner's Name: ______________________Partner's Age: __________
Referring Physician: ______________________
PCP if different: ______________________

Medical History

Have you had any of the following illnesses?

- cancer__________________
- --If yes, type of chemo__________
- chronic lung disease/recurrent bronchitis ____
- chronic renal failure __________
- diabetes __________________
- inflammatory bowel disease __________
- mumps orchitis __________
- neurologic disorder__________
- seizure disorder __________
- spinal or back injury__________
- tuberculosis __________
- thyroid disease __________

Have you ever taken any of these medicines?

- cimetidine__________
- cyclosporine ________
- dilantin__________
- ketoconazole__________
- nitrofurantoin__________
- predisone __________
- procardia__________
- spironolactone________
- sulfasalazine________

Have you had any of these operations?

- bladder neck ________
- hydrocele__________
- hypospadias________
- inguinal hernia repair______
- prostatectomy__________
- undescended testicle______
- spermatocele________
- varicocelectomy______
- vasectomy__________

Have you ever had any of the following infections?

- chlamydia__________________
- gonorrhea__________________
- herpes__________________
- HIV__________________
- syphilis__________________

Please answer Yes or No to the following questions.

	Yes	No
Have you had a high fever in the last 6 months?		
Have you had a urinary tract infection / prostatitis ?		
Have you had epididymitis?		
Have you had testicular torsion?		
Have you had trauma to one or both testicles?		

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Fertility Questions

How long have you and your partner been attempting to conceive? ______ months

Have you been involved in a previous pregnancy?

Current partner yes____ no____ When? ___________ # of pregnancies____

Another partner yes____ no____ When?___________ # of pregnancies____

Has your partner ever been pregnant? yes____ no____

If yes, When?_______ Number of times _____ How many births_____

Does your partner have any Gynecologic issues that affect fertility? yes____ no____

If yes please list: ____

____

____

Is ovulation regular? yes____ no____

Is there a family history of infertility? yes____ no____

Did your mother use DES during her pregnancy with you? yes____ no____

Are there any problems with erectile dysfunction? yes____ no____

premature ejaculation? yes____ no____

intra-vaginal ejaculation? yes____ no____

What is your average frequency of intercourse?

Less than once per month____ Once or twice per month____ Once a week____

Two or three times per week____ Daily____

Are you using any lubricants for intercourse? yes____ no____

If yes what are you using? ____

Have you attempted to time intercourse with ovulation? yes____ no____

Have you used ovulation predictor kits? yes____ no____

Have you had a prior evaluation or treatment for infertility? yes____ no____

What was done? ____

____

Environmental Exposure

Do you smoke cigarettes, cigars or a pipe? yes____ no____

How much? ______________________________

Did you smoke in the past? yes____ no____

When did you quit? _______________________

Are you exposed to second hand smoke? yes____ no____

Do you use any of the following?

marijuana____ cocaine____ heroin____ methadone____

narcotic pain meds____ steroids for body building____

Do you drink alcohol? yes____ no_____

rarely____ monthly____ weekly____ daily____ How much? _____

Do you take dietary supplements? yes____ no_____

List the supplements ____

____

Are you exposed to pesticides? yes____ no____

Are you exposed to radiation or x rays? yes____ no____

Are you exposed to toxic chemicals or industrial solvents? yes____ no____