

NORTHWEST SUBURBAN UROLOGY ASSOCIATES, S.C.

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Male Infertility Questionnaire

Patient Name: _____ Date: _____

Please answer the following questions as completely as possible and return this form to the receptionist when you have finished. The doctor will take time to review this information prior to calling you in to the office.

- 1) What is your age? _____ years What is your mate's age? _____ years
- 2) How long have you been married to your present mate? _____ years
- 3) Is this your first marriage? ____ Yes ____ No If No, number of previous marriages: _____
- 4) How long have you been trying to conceive a child? _____ yrs _____ mnths
- 5) Does your mate have any children from a previous marriage? ____ Yes ____ No
- 6) Have you ever fathered a child? ____ Yes ____ No If yes, ages: _____
 - a) Have you ever impregnated a woman who subsequently had an induced or spontaneous abortion? ____ Yes ____ No
 - b) Have you ever fathered a malformed child or a child with any birth defect? ____ Yes ____ No If Yes, please explain: _____

- 7) Do you have any relatives (mother, father, brothers, sisters, aunts, uncles) who have birth defects or who have given birth to children with birth defects or mental retardation? ____ Yes ____ No If Yes, please explain: _____

- 8) Have your mother or sisters had any spontaneous abortions? (miscarriages) ____ Yes ____ No If Yes, please explain: _____

- 9) Have your sisters or brothers had any fertility problems? ____ Yes ____ No If Yes, please explain: _____

- 10) Have your mother, sisters, or aunts ever been told they had endometriosis? ____ Yes ____ No If Yes, please explain: _____

- 11) Have you ever had any type of surgery? ____ Yes ____ No If Yes, please list type of surgery and date(s): _____

12) Have you ever been hospitalized other than for surgery? Yes No

If Yes, please list dates and diagnosis:

13) Does anyone in your immediate family have any of the following diseases?

- a) diabetes - insulin dependent Yes No
- b) diabetes - controlled on diet or oral medication Yes No
- c) high blood pressure (hypertension) Yes No
- d) epilepsy Yes No
- e) cancer Yes No Type(s): _____
- f) kidney disease Yes No
- g) ulcerative colitis Yes No
- h) gastric (stomach) ulcers Yes No
- i) migraine headaches Yes No
- j) heart disease Yes No
- k) thyroid disease Yes No
- l) psychiatric disease Yes No
- m) blood disease of any type Yes No
- n) arthritis Yes No
- o) tuberculosis Yes No

14) Do you have any of the following diseases?

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Please list any medical problems that you have that are not included in the above list:

15) Please list all medications you take and their dosages: _____

16) Are you allergic to any medications? Yes No If Yes, please list the medicine and the type of reaction you have: _____

17) Do you smoke cigarettes? ____ Yes ____ No If Yes, packs per day? _____
How many years have you smoked? _____ years

18) Do you use marijuana? ____ Yes ____ No If Yes, number of times of use per week?
_____ times Duration of use? _____ years

Please list any other street drugs you use: _____

19) Do you drink alcohol? ____ Yes ____ No If Yes, number of cocktails, beers, and glasses of
wine per week? _____ cocktails _____ beers _____ wine

20) What is your present occupation? _____

21) Are you exposed to any adverse environmental conditions (ie. heat, cold, etc.) or toxic chemicals?
____ Yes ____ No If Yes, please explain: _____

22) Do you use a hot tub, sauna, or steambath? ____ Yes ____ No

23) Are you away from home frequently on trips? ____ Yes ____ No If Yes, please give number of
days away per month: _____ days

24) Do you feel that you are under greater stress than the average person? ____ Yes ____ No

25) Do you feel that you are a healthy person? ____ Yes ____ No If No, please explain:

26) Please list your height: _____ ft. _____ in. weight: _____ lbs.
Have you recently gained weight? ____ lost weight? ____ # of lbs. _____

27) Do you take vitamins or any dietary supplement? ____ Yes ____ No If Yes, please explain:

28) Within the last year, have you been on any special diets? ____ Yes ____ No
If Yes, please give diets and dates: _____

29) Have you ever taken thyroid medication? ____ Yes ____ No

30) Have you ever had a urinary tract (bladder or kidney) infection? ____ Yes ____ No If Yes,
please give dates: _____

31) Have you ever had the mumps? ____ Yes ____ No If Yes, was it before, during or after
puberty? _____ before _____ during _____ after

32) Have your testicles ever been sore, swollen, or injured? ____ Yes ____ No
If Yes, please give dates and any treatment you received: _____

33) Have you ever had any of the following diseases? If Yes, please give dates and treatment received:

- _____ gonorrhea _____
 - _____ syphilis _____
 - _____ non-specific urethritis _____
 - _____ discharge from the penis (undiagnosed) _____
 - _____ herpes (painful blisters on penis or scrotum) _____
 - _____ undescended testis _____
 - _____ prostatitis _____
 - _____ epididymitis _____
-
- _____ hepatitis _____
 - _____ mononucleosis _____
 - _____ condyloma (venereal warts) _____

34) Have you ever been treated by another urologist? _____ Yes _____ No
If Yes, please list physician's name, address, and dates you were seen:

35) Are you satisfied with your sex life? _____ Yes _____ No

36) Do you feel that having a problem with infertility has harmed your sexuality as a couple?
_____ Yes _____ No

37) Does having "timed" intercourse harm your sex life or satisfaction? _____ Yes _____ No

38) Does your mate, in your opinion, have any sexual problems? _____ Yes _____ No
If Yes, please explain: _____

39) Most men occasionally have a problem maintaining an erection. Do you frequently have this problem? _____ Yes _____ No

40) Do you have trouble ejaculating? _____ Yes _____ No

41) Do you have any problem with premature ejaculation? (male ejaculating too quickly)
_____ Yes _____ No

42) Do you use any lubricant with intercourse? _____ Yes _____ No

43) Have you ever had a sperm count? _____ Yes _____ No If Yes, please see that we receive those results.

44) Have you had any high fevers in the past six months? _____ Yes _____ No
If Yes, please explain when and how high: _____

45) Frequency of sexual intercourse? _____ per week _____ per month