

Urological Consultants, PA
Male Fertility Evaluation Questionnaire

Name _____

Address _____

Birthdate _____ Age _____

Partner's Name _____ Partner's Age _____

Marital Status _____

Who referred you? _____

Relationship to you? _____

Fertility History

How many months have you been trying to achieve pregnancy with your current partner? _____

Have you ever achieved a pregnancy with your partner in the past? _____

If yes, please give dates and outcomes of those pregnancies _____

Did you use birth control before attempting to conceive? _____

If yes, what birth control methods did you use? _____

Have you ever contributed to a pregnancy with another partner? _____

If yes, please give the dates and outcomes of those pregnancies _____

Has your current partner ever had a pregnancy with another man? _____

If yes, please give the dates and outcomes of those pregnancies _____

Has your current partner had any tests for evaluation of her fertility? _____

If yes, please describe the results of those tests: _____

Past Medical History

	Yes	No		Yes	No
Allergy to medications	___	___	High Blood Pressure	___	___
Arthritis	___	___	Liver Problems	___	___
Bowel Disorders	___	___	Lung Problems	___	___
Cancer	___	___	Thyroid Disease	___	___
Color Blindness	___	___	Nervous system disease	___	___
Diabetes	___	___	Sickle Cell Disease	___	___
Back or Neck Problems	___	___	Sinus Problems	___	___
Heart Problems	___	___	Skin Diseases	___	___
Hepatitis	___	___	Spinal Cord Problems	___	___

Prescription medications taken on a regular basis:

Over the counter medications taken on a regular basis (including vitamins and/or supplements):

Urological History

Have you ever had an infection involving:

	Yes	No	When?
Prostate	___	___	_____
Epididymis	___	___	_____
Testes	___	___	_____
Venereal disease	___	___	_____
Urethritis	___	___	_____
Herpes	___	___	_____
Urinary Tract Infection	___	___	_____
Blood in your semen?	___	___	_____
Pain with ejaculation?	___	___	_____
Swelling of the testes?	___	___	_____

Surgical History

Urinary tract surgery?	___	___	_____
Vasectomy?	___	___	_____
Vasectomy reversal?	___	___	_____
Hernia repair?	___	___	_____
Varicocele repair?	___	___	_____
Hydrocele repair?	___	___	_____
Testis biopsy?	___	___	_____
Other testis surgery?	___	___	_____
Penis surgery?	___	___	_____

Maturation and Development

Did your armpit and pubic hair develop at the same time as other boys your age?	___	___	
If not, when did you go through puberty?	_____		
Do you have frequent headaches	___	___	
Has your vision changed recently	___	___	
Recent change in energy level	___	___	

Social History /Drug Exposures

	Yes	No
Do you take long hot baths?	___	___
Saunas?	___	___
Jacuzzis?	___	___
Do you smoke cigarettes?	___	___
If so, how many packs per day?	_____	
Do you smoke marijuana ?	___	___
How many alcoholic beverages per week?	_____	
Ever more than 2 per day?	___	___
How many cups of coffee or tea per day?	_____	
What kind of work do you do?	_____	
Are you ever exposed to toxins, poisons, pesticides, radiation or solvents?	_____	

Sexual History

Rate your interest in sex (circle one): *None* *Minimal* *Moderate* *Intense*

How many times per week do you ejaculate? _____

How many times per week do you masturbate? _____

	Yes	No
Do you ejaculate during intercourse?	___	___
Do you ejaculate vaginally?	___	___
Do you have erectile dysfunction?	___	___
Do you ever ejaculate before penetration?	___	___
Is intercourse ever painful for your partner?	___	___
Do you use any lubricants during sex?	___	___
Does your partner lie down for 30 minutes after intercourse?	___	___
Does your partner douche after sex?	___	___
Do you have sex daily or every other day when your partner is ovulating?	___	___

Family History

	Yes	No
How many brothers do you have?	_____	
Do any have fertility problems?	___	___
How many sisters do you have?	_____	
Do any have fertility problems?	___	___
Was your mother given DES to prevent miscarriage?	___	___
Does anyone in your family have:		
Birth Defects	___	___
Cystic Fibrosis	___	___
Hormone problems	___	___
Infertility	___	___