

Date: _____

GENERAL UROLOGY QUESTIONNAIRE

Please fill out the following form as honestly and completely as you can. The purpose of this information is to help assess your reproductive potential. Your thoroughness in its completion is essential to evaluation and treatment. All information will be held in strict confidence. Please bring this form with you on your first visit.

PRIMARY REASON FOR YOUR VISIT: _____

A. Identification:

Name: _____

Address: _____

Birthdate: _____ Birthplace: _____

Ethnic Origin: _____

Age: _____

Gender: Male Female

Telephone (home): _____

Telephone (work): _____

Referred by: _____

Who is your primary Medical Doctor: _____

Please list in order of importance (the most important first) all concerns you have regarding your health and well-being:

Marital Status:

single__divorced__married__separated__widowed__

Partners name: _____ Age: _____ Gender: Male Female

B. Fertility History:

1. Have you achieved pregnancy with your current partner in the past? _____
If yes, please give dates _____ and note any adverse outcome _____

2. Have you had a pregnancy with a previous partner? _____
If yes, please give dates _____ and note any adverse outcome _____

3. Have you ever undergone sterilization (e.g., vasectomy)? _____

4. Have you received treatment for infertility problems elsewhere? _____

C. Sexual History:

1. Rate your level of sexual desire:
marked__moderate__slight__none__

2. How many times each week do you have sexual activity (e.g., intercourse, masturbation)?

3. Rate you partners level of sexual desire:
marked__moderate__slight__none__

YES NO Please list treatments

Men:

7. Do you obtain an erection easily? _____

8. Do you often have erections in the morning? _____

9. Are you aware of erections in the night? _____

10. Have you ever ejaculated through a flaccid (soft) penis? _____

11. Do you often ejaculate prior to penetration for intercourse? _____

Women:

12. Do you have pain with intercourse? _____

13. Do you feel that you have adequate lubrication with sexual excitement? _____

14. Have you noticed a change in your sexual response? _____

	YES	NO	Please describe
15. Are you subject to vaginal infections?	_____	_____	_____
16. Are your menstrual periods regular (LMP)?	_____	_____	_____
17. Are you post (or peri) menopausal (LMP)?	_____	_____	_____
18. Have you had a hysterectomy?	_____	_____	_____
19. Do you take hormone replacement?	_____	_____	_____
<u>Both Men and Women:</u>			
16. Do you use any form of lubrication for intercourse? if so, what type	_____	_____	_____
17. Rate you partners level of sexual desire: marked____;moderate____;slight____;none____			
18. Have you or your partner ever had any of the following illnesses? If so, please note date and treatment: Herpes simplex (Type I or II): Pelvic inflammatory disease (PID): Venereal disease (VD): Gonorrhea (GC): Non-specific urethritis (NSU): Syphilis:	_____	_____	_____
19. Do you or have you had kidney disease (stone, infection, tumor etc) Please describe:	_____	_____	_____
20. Do you or have you had Bladder disease (stone, infection, tumor, incontinence)____ Please describe:	_____	_____	_____
21. Does urine leak out when you cough, sneeze, laugh or with physical excersie?____ If so, do you wear pads? _____ How many/day?_____	_____	_____	_____
22. Do you wet the bed at night?	_____	_____	_____
23. Do you have pain with urination?	_____	_____	_____
24. Do you have blood in your urine?	_____	_____	_____
25. Do you have recurrent urinary infections?	_____	_____	_____

D. General Medical History:

1. Have you ever had any of the following illnesses or conditions:			
Allergies (Medicines, Enviornmental, Foods: please list)	_____	_____	_____
Arthritis	_____	_____	_____
Bowel disorders	_____	_____	_____
Cancer	_____	_____	_____
Change in body appearance	_____	_____	_____
Change in facial appearance	_____	_____	_____
Color blindness	_____	_____	_____
Deafness	_____	_____	_____
Diabetes	_____	_____	_____
Heart problems	_____	_____	_____
Hepatitis	_____	_____	_____
HIV infection (AIDS)	_____	_____	_____
Liver Disease	_____	_____	_____
Lung or breathing problems	_____	_____	_____
Thyroid disease	_____	_____	_____
Generalized viral infection (i.e.,mono,encephalitis)	_____	_____	_____
Nervous system or Psychiatric disease	_____	_____	_____
Sickle cell disease	_____	_____	_____
Smallpox	_____	_____	_____
Influenza	_____	_____	_____
Tuberculosis	_____	_____	_____
Ulcers	_____	_____	_____
Frequent episodes of indigestion or abdominal pain	_____	_____	_____
Neck or back problems	_____	_____	_____
Skin diseases	_____	_____	_____
High blood pressure	_____	_____	_____
Seasonal illnesses (e.g.,respiratory, skin, GI)	_____	_____	_____

E. Urological History:

	NA	YES	NO	Please List Treatments
1. Have you ever had infection of the:				
prostate	_____	_____	_____	_____
epididymis	_____	_____	_____	_____
testicles	_____	_____	_____	_____
bladder	_____	_____	_____	_____
kidney	_____	_____	_____	_____
2. Have you ever had kidney stones?	_____	_____	_____	_____
3. Have you had:				
venereal disease (VD)	_____	_____	_____	_____
non-specific urethritis (NSU)	_____	_____	_____	_____
Gonorrhea (GC)	_____	_____	_____	_____
Syphilis	_____	_____	_____	_____
Herpes simplex (Type I or II)	_____	_____	_____	_____
4. Have you ever had a clear, white, yellow or green discharge from the tip of your urethra?	_____	_____	_____	_____
5. Have you ever had a urinary tract infection (UTI)?	_____	_____	_____	_____
6. Have you had a fever in the past three months?	_____	_____	_____	_____
7. Have you ever had blood in your semen (ejaculate)?	_____	_____	_____	_____
8. Have you ever had pain in your scrotum or testicles?	_____	_____	_____	_____
9. Were either of your testicles undescended at birth?	_____	_____	_____	_____
10. Have you ever had any injury to your testicles or penis?	_____	_____	_____	_____
11. Have you ever had mumps?	_____	_____	_____	_____
if yes, did it affect your testicles:_____				
12. Have you ever had an operation for (please give dates):				
Hernia	_____	_____	_____	_____
Varicocele (varicose veins in the scrotum)	_____	_____	_____	_____
Hydrocele	_____	_____	_____	_____
Undescended testis	_____	_____	_____	_____
Any abdominal surgery	_____	_____	_____	_____
Operation on the testis	_____	_____	_____	_____
Vasectomy	_____	_____	_____	_____
Circumcision or other surgery on the penis	_____	_____	_____	_____
Operation on on Uterus or vagina	_____	_____	_____	_____
Operation on Ovary of fallopian tube	_____	_____	_____	_____
Other surgery (please list with dates)	_____	_____	_____	_____
Have you ever had a blood transfusion (Date)	_____	_____	_____	_____

F. Endocrine History:

1. Do you have or have you ever had:	YES	NO	
Difficulty smelling	_____	_____	_____
Headaches (persistent or recurrent)	_____	_____	_____
Visual problems	_____	_____	_____
Enlarging hands or feet	_____	_____	_____
Problems with perspiration/sweating	_____	_____	_____
Changing skin color	_____	_____	_____
Frequent episodes of lightheadedness or dizziness	_____	_____	_____
Growth problems	_____	_____	_____
Do you have a general sense of well being	_____	_____	_____
Do you notice a recent change in your energy level	_____	_____	_____
Do you have wide mood swings	_____	_____	_____
2. At what age did you first:			
note armpit hair _____			
pubic hair _____			
shave _____			

3. How often do you shave:
 once a day__ twice a day__ once a week__ twice a week or less__
4. Is there any change in the texture or quantity of body hair?
5. How does your beard compare with other men in your family:
 same__ sparser__ heavier

G. Occupational/Educational History:

1. What is your highest level of education (circle one): High School, College, Graduate School
2. Please list any College Degrees (with Major):_____
3. What is your present occupation?_____
4. Past occupations?_____ YES NO INDICATION
5. Is your occupation stressful? _____
6. Do you need to meet rigid deadlines or time schedules? _____
7. Do you frequently travel? _____
8. Do you fall asleep easily? _____
9. Do you wake up early? _____

10. In your work have you been exposed to any of the following:

- Prolonged heat _____
- Radiation _____
- Pesticides _____
- Agent orange _____
- Industrial solvents _____
- Dyes _____
- Heavy metals _____
- Plastics _____

H. Medications and Drugs:

1. Are you taking or have you taken any of the following medications:

- Allopurinol _____
- Antidepressant drugs _____
- Antihistamines _____
- Antihypertensive drugs _____
- Antiparasite agents _____
- Anti psychotic agents _____
- Aspirin _____
- Barbituates _____
- Chemotherapy for cancer _____
- Cholestyramine _____
- Clofibrate _____
- Digitalis _____
- Dilantin _____
- Diuretics _____
- Hormones (estrogen, testosterone, thyroid, cortisone) _____
- Immunosuppressant drugs _____
- Insulin _____
- Nicotinic acid _____
- Norpace _____
- Penicillin _____
- Streptomycin _____
- Sulfa drugs _____
- Tagamet (Cimetadine) _____
- Tetracycline _____
- Tranquilizers _____

2. Please list all medications you are currently taking (please include dosage and frequency): _____

YES NO

I. Social History:

- 1. Do you smoke? _____
- if yes, how many cigarettes do you smoke each day? _____
- Have you tried ever quitting? _____
- 2. Do you consume alcoholic beverages (if yes, how often)? _____
- 3. How many cups of coffee or caffeine-containing beverages do you drink each day? _____
- 4. Do you use any of the following substances:
 - Amphetamines _____
 - Quaaludes _____
 - Marijuana _____
 - Cocaine _____
 - LSD _____
 - Angel dust _____
 - Heroin _____
 - Methadone _____
- 5. Do you exercise? _____
- Primary activity: _____ Duration/day: _____ How many years? _____

J. Family History:

- 1. Was your mother ever given diethylstilbesterol (DES)? _____
- 2. How many sisters do you have? _____
- Please give the number of children of each of your sisters:
sister #1 _____ sister #2 _____ sister #3 _____ sister #4 _____
- 3. How many brothers do you have? _____
- Please give the number of children of each of your brothers:
brother #1 _____ brother #2 _____ brother #3 _____ brother #4 _____
- 4. Are any of the following diseases or conditions present in your family?
 - birth defects _____
 - Bowel disorders _____
 - Cancer _____
 - Cystic fibrosis _____
 - Diabetes _____
 - Extra fingers or toes _____
 - Heart disease _____
 - High blood pressure _____
 - Hormone problems _____
 - Kidney disease _____
 - Lung disease _____
 - Poor sense of smell _____
 - Tuberculosis _____
 - Ulcers _____
 - Other _____

K. CAM

- 1. Have you ever been treated with:

	<u>Experience(Results)</u>		
	Good	Fair	Poor
Acupuncture	_____	_____	_____
Ayurveda	_____	_____	_____
Chiropractic Medicine	_____	_____	_____
Electromagnetic therapy	_____	_____	_____
Herbal therapy	_____	_____	_____
Homeopathy	_____	_____	_____
Hypnosis	_____	_____	_____
Massage Therapy	_____	_____	_____
Naturopathy	_____	_____	_____
- 2. Color preference (please circle one): Blue-Green, Red, Earth tones (tan, yellow-brown), White, Black
- 3. Flavor preference (please circle one): Sour, Bitter-Roasted, Sweet, Spicy, Salty
- 4. Seasonal preference (please circle one): Spring, Summer, Fall-Autumn, Winter