

Date:

## **MALE REPRODUCTION QUESTIONNAIRE (Adolescent)**

*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.*

### **A. Identification:**

Name:

Address:

Birthdate:

Birthplace:

Ethnic Origin:

Age:

Telephone (home):

Telephone (work):

Referred by:

### **A. General Medical History:**

	YES	NO
1. Have you ever had any of the following illnesses or conditions:		
<b>Allergies</b> (please list)	___	___
Arthritis	___	___
Bowel disorders	___	___
Cancer	___	___
Change in body appearance	___	___
Change in facial appearance	___	___
Color blindness	___	___
Deafness	___	___
Diabetes	___	___
Heart problems	___	___
Hepatitis	___	___
HIV (AIDS)	___	___
Liver Disease	___	___
Lung or breathing problems	___	___
Thyroid disease	___	___
Generalized viral infection (i.e.,mono,encephalitis)	___	___
Nervous system disease	___	___
Sickle cell disease	___	___
Smallpox	___	___
Influenza	___	___
Tuberculosis	___	___
Ulcers	___	___
Frequent episodes of indigestion or abdominal pain	___	___
Neck or back problems	___	___
Skin diseases	___	___
High blood pressure	___	___

**B. Urological History:**

	YES	NO
1. Have you ever had infection of the:		
prostate	___	___
epididymis	___	___
testicles	___	___
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 penis?	___	___
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 both of your testicles descended 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	___	___
Other surgery (please list with dates)	___	___
Have you ever had a blood transfusion (Date)	___	___

**F. Endocrine History:**

	YES	NO
1. Do you have or have you ever had:		
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

**C. Occupational History:**

1. What is your present occupation?

2. Past occupations?

YES NO

3. Is your occupation stressful? \_\_\_\_\_

4. Do you need to meet rigid deadlines or time schedules? \_\_\_\_\_

5. Do you frequently travel? \_\_\_\_\_

6. Do you fall asleep easily? \_\_\_\_\_

7. Do you wake up early? \_\_\_\_\_

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

Prolonged heat \_\_\_\_\_

Radiation \_\_\_\_\_

Pesticides \_\_\_\_\_

Agent orange \_\_\_\_\_

Industrial solvents \_\_\_\_\_

Dyes \_\_\_\_\_

Heavy metals \_\_\_\_\_

Plastics \_\_\_\_\_

**D. 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):

**E. Social History:**

**YES NO**

1. Do you smoke?  
if yes, how many cigarettes do you smoke each day? \_\_\_\_\_
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 often take long hot baths? \_\_\_\_\_

**F. 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 \_\_\_\_\_
5. Have either you or any family member had any of the following (if so, please note relation and type [if known])  
Congenital (present at birth) malformations: \_\_\_\_\_  
Genetic diseases or disorders: \_\_\_\_\_