

Date:

## MALE REPRODUCTION 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.*

### A. Identification:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Ethnic Origin: \_\_\_\_\_

Age: \_\_\_\_\_

Telephone (home): \_\_\_\_\_

Telephone (work): \_\_\_\_\_

Referred by: \_\_\_\_\_

Marital Status:

single \_\_ divorced \_\_ married \_\_ separated \_\_ widowed \_\_

Partners name: \_\_\_\_\_ Her age: \_\_\_\_\_

### B. Fertility History:

1. For how many months have you been trying to achieve pregnancy with your current partner? \_\_\_\_\_

2. Have you achieved pregnancy with your current partner in the past? \_\_\_\_\_

If yes, please give dates (a-d) and note any adverse outcome (e-h):

\_\_\_\_ (a) normal delivery      \_\_\_\_ (e) stillbirth  
\_\_\_\_ (b) spontaneous abortion      \_\_\_\_ (f) birth defects  
\_\_\_\_ (c) induced abortion      \_\_\_\_ (g) premature birth  
\_\_\_\_ (d) ectopic pregnancy      \_\_\_\_ (h) caesarean section

3. Have you made any previous partner pregnant? \_\_\_\_\_

If yes, please give dates (a-d) and note any adverse outcome (e-h):

\_\_\_\_ (a) normal delivery      \_\_\_\_ (e) stillbirth  
\_\_\_\_ (b) spontaneous abortion      \_\_\_\_ (f) birth defects  
\_\_\_\_ (c) induced abortion      \_\_\_\_ (g) premature birth  
\_\_\_\_ (d) ectopic pregnancy      \_\_\_\_ (h) caesarean section

4. Has your current partner had any pregnancies previously with someone other than you? \_\_\_\_\_

If yes, please give dates (a-d) and note any adverse outcome (e-h):

\_\_\_\_ (a) normal delivery      \_\_\_\_ (e) stillbirth  
\_\_\_\_ (b) spontaneous abortion      \_\_\_\_ (f) birth defects  
\_\_\_\_ (c) induced abortion      \_\_\_\_ (g) premature birth  
\_\_\_\_ (d) ectopic pregnancy      \_\_\_\_ (h) caesarean section

5. For how many months have you used any of the following contraception methods? (Please give dates, if possible)

- Condom: \_\_\_\_\_
- Diaphragm: \_\_\_\_\_
- Foam: \_\_\_\_\_
- IUD: \_\_\_\_\_
- Pills: \_\_\_\_\_
- Rhythm: \_\_\_\_\_

- 6. Have you ever undergone sterilization (e.g., vasectomy)? \_\_\_\_\_
- 7. Has your partner ever undergone sterilization (e.g., tubal ligation)? \_\_\_\_\_
- 8. Have you been examined for infertility problems elsewhere (please list MD)? \_\_\_\_\_
- 9. 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 intercourse? \_\_\_\_\_
- 3. How many times each week do you masturbate? \_\_\_\_\_
- 4. Do you ejaculate during sexual intercourse? \_\_\_\_\_
- 5. Do you ejaculate into your partners vagina? \_\_\_\_\_
- 6. Does semen leak out of your partners vagina after intercourse? \_\_\_\_\_
- 7. Do you ever ejaculate prior to penetration for intercourse? \_\_\_\_\_
- 8. How many minutes does intercourse last before you ejaculate? \_\_\_\_\_
- 9. Do you obtain an erection easily? \_\_\_\_\_
- 10. Do you often have erections in the morning? \_\_\_\_\_
- 11. Are you aware of erections in the night? \_\_\_\_\_
- 12. Have you ever ejaculated through a flaccid (soft) penis? \_\_\_\_\_
- 13. Do you often ejaculate prior to penetration for intercourse? \_\_\_\_\_
- 14. Is intercourse ever painful to you? \_\_\_\_\_
- 15. Is intercourse painful for your partner? \_\_\_\_\_
- 16. Is your partners vagina so tight that you cannot penetrate? \_\_\_\_\_
- 17. Do you use any form of lubrication for intercourse?  
if so, what type \_\_\_\_\_

- 18. Rate you partners level of sexual desire:  
marked \_\_\_; moderate \_\_\_; slight \_\_\_; none \_\_\_
- 19. Are your partners menstrual periods regular? \_\_\_\_\_
- 20. Do you have intercourse every other day during expected ovulation? \_\_\_\_\_
- 21. Is your partner subject to vaginal infections? \_\_\_\_\_
- 22. Has 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: \_\_\_\_\_

- 23. Has your partner had abdominal surgery? \_\_\_\_\_
- 24. Does your partner douche immediately following intercourse? \_\_\_\_\_
- 25. Does your partner usually get out of bed shortly following intercourse? \_\_\_\_\_

YES NO

- 26. Have you ever had same sex intercourse (anal or oral)? \_\_\_\_\_
- 27. Have you engaged in sex for pay within the past 5 years? \_\_\_\_\_
- 28. Has any prior partner tested positive for the HIV (human immunodeficiency virus)? \_\_\_\_\_

**D. General Medical History:**

- 1. Have you ever had any of the following illnesses or conditions: \_\_\_\_\_  
**Allergies** (please list) \_\_\_\_\_

	YES	NO	
Arthritis (or other autoimmune disease)	_____	_____	
Bowel disorders	_____	_____	
Cancer (Please describe):	_____	_____	
Change in body appearance	_____	_____	
Change in facial appearance	_____	_____	
Color blindness	_____	_____	
Deafness	_____	_____	
Diabetes	_____	_____	
Heart problems	_____	_____	
Hepatitis	_____	_____	Type: _____
HIV infection (AIDS)	_____	_____	
Liver Disease	_____	_____	
Lung or breathing problems	_____	_____	
Thyroid disease	_____	_____	
Generalized viral infection (i.e., mono, encephalitis)	_____	_____	
Nervous system disease (e.g., Creutzfeldt-Jacob, Multiple Sclerosis, Alzheimer's, encephalitis)	_____	_____	
Sickle cell disease	_____	_____	
Smallpox	_____	_____	
Influenza	_____	_____	
Tuberculosis	_____	_____	
Ulcers	_____	_____	
Frequent episodes of indigestion or abdominal pain	_____	_____	
Neck or back problems	_____	_____	
Skin diseases	_____	_____	
High blood pressure	_____	_____	
Receipt of Pituitary Growth Hormone	_____	_____	Date of last treatment: _____
Blood transfusions	_____	_____	Date of last treatment: _____
Received Blood components (e.g., factor VIII, IX or others)	_____	_____	Date of last treatment: _____

**E. Urological History:**

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 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	_____	_____
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 History:**

1. What is your present occupation? \_\_\_\_\_

2. Past occupations? \_\_\_\_\_

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 or at any other times, have you been exposed to any of the following:

Prolonged heat	_____	_____
Radiation	_____	_____
Pesticides	_____	_____
Agent orange	_____	_____
Industrial solvents	_____	_____
Dyes	_____	_____
Heavy metals (e.g., lead, mercury, gold)	_____	_____
Plastics	_____	_____

YES NO

**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): \_\_\_\_\_

**I. Social History:**

- 1. Do you smoke? \_\_\_\_\_
  - b. 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. Have you ever been an inmate in a correctional facility \_\_\_\_\_ When \_\_\_\_\_ Duration \_\_\_\_\_
- 5. Do you use any of the following substances:
  - Amphetamines \_\_\_\_\_
  - Quaaludes \_\_\_\_\_
  - Marijuana \_\_\_\_\_
  - Cocaine \_\_\_\_\_
  - LSD \_\_\_\_\_
  - Angel dust \_\_\_\_\_
  - Heroin \_\_\_\_\_
  - Methadone \_\_\_\_\_
  - Any nontherapeutic injected drug use \_\_\_\_\_ Date of last use: \_\_\_\_\_
- 6. Do you often take long hot baths? \_\_\_\_\_
- 7. Do you have any tattoos or skin piercings? \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_
- 8. Have you been bitten from an animal suspected of having rabies? \_\_\_\_\_ When \_\_\_\_\_

YES NO

**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 \_\_\_\_\_  
Any known genetic disease \_\_\_\_\_  
Tay-Sachs disease \_\_\_\_\_  
Thalassemia (alpha or beta types) \_\_\_\_\_  
Cystic fibrosis \_\_\_\_\_  
Sicle cell disease \_\_\_\_\_

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: \_\_\_\_\_ Please describe: \_\_\_\_\_  
Genetic diseases or disorders: \_\_\_\_\_ Please describe: \_\_\_\_\_

**H. Partner History:**

1. Has your partner been seen by a fertility specialist? (if so, please list and give dates)? \_\_\_\_\_ Please describe: \_\_\_\_\_

2. Has your partner had any of the following tests/procedures? (if so, please note date and result [if known])  
Basal body temperature (BBT): \_\_\_\_\_ Results::: \_\_\_\_\_  
Blood tests (FSH,LH, estradiol): \_\_\_\_\_ Results::: \_\_\_\_\_  
Post coital test (PCT): \_\_\_\_\_ Results::: \_\_\_\_\_  
Hysterosalpingography (HSG): \_\_\_\_\_ Results::: \_\_\_\_\_  
Endometrial biopsy: \_\_\_\_\_ Results::: \_\_\_\_\_  
Laparoscopy: \_\_\_\_\_ Results::: \_\_\_\_\_  
IUI or IVF cycles: \_\_\_\_\_ Results::: \_\_\_\_\_

3. Does your partner have any allergies (including any medication or food allergies)? If so please list each and describe reaction. \_\_\_\_\_ Please describe: \_\_\_\_\_