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 | ___ | ___ |