

Male Fertility Evaluation Questionnaire

Please complete this questionnaire as completely & honestly as possible. Please bring this form with you to your initial consultation with Dr. Schlegel. If any semen analyses, blood tests, or other evaluations have been previously performed, please bring these reports and/or have any other doctors fax the reports to us at (212) 746-8425. If a testis biopsy has been performed, please bring the glass slides of the biopsy (obtained from The Department of Pathology where the biopsy was done.)

Background Information:

Name: _____
 Address: _____
 Birthdate: _____ Age: _____
 Telephone: (Work) (____) _____ - _____
 Telephone: (Home) (____) _____ - _____
 Partner's Name: _____
 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 date & outcome of pregnancies:

How many months have you lived with your partner: __
 Did you use birth control before attempting to conceive?: ____
 What methods did you use?:

Have you ever contributed to a pregnancy with another partner?: _____
 Please present the outcome of these pregnancies:

Has your current partner ever had any pregnancies with another man?: _____
 Please describe the outcome of these pregnancies:

How old is your partner?: _____
 Has she had any tests for evaluation of her fertility?:

Does she ovulate every month? _____

Past Medical History:

	Yes	No	Age at Diagnosis
Allergy to medications	—	—	_____
Arthritis	—	—	_____
Bowel Disorders	—	—	_____
Cancer	—	—	_____
Change in Body Appearance	—	—	_____
Color Blindness	—	—	_____
Deafness	—	—	_____
Diabetes	—	—	_____
Disk Problems	—	—	_____
Heart Problems	—	—	_____
Hepatitis	—	—	_____
High Blood Pressure	—	—	_____
Indigestion or frequent abdominal pain	—	—	_____
Diagnosis			
Other Liver Problems	—	—	_____
Lung or Breathing Problems	—	—	_____
Thyroid Disease	—	—	_____
Nervous System Diseases	—	—	_____

Sickle Cell Disease	—	—	_____
Sinus Problems	—	—	_____
Skin diseases	—	—	_____
Spinal cord problems	—	—	_____
Tuberculosis	—	—	_____
Ulcers	—	—	_____
Any medications taken on a regular basis (& dose):			

Have you been given any antibiotics in the past 3 months?:

Have you ever taken any of the following medications:

Allopurinol	—	—
Antidepressant drugs	—	—
Antihypertensive drugs	—	—
Antiparasitic Agents	—	—
Antipsychotic medications	—	—
Barbiturates	—	—
Chemotherapy for cancer	—	—
Cholesterol-lowering drugs	—	—
Clomid	—	—
Dilantin	—	—
hCG injections	—	—
Hormones	—	—
Immunosuppressant drugs	—	—
Insulin	—	—
Tagamet (cimetidine)	—	—
Tranquilizers	—	—
Zantac (ranitidine)	—	—
Zovirax (acyclovir)	—	—

Urological History

Have you ever had an infection involving:

Prostate (or prostatitis)	—	—	_____
Epididymis (epididymitis)	—	—	_____
Testes	—	—	_____
Venereal (sexually transmitted) infection	—	—	_____
Urethritis (or NSU)	—	—	_____
Gonorrhea	—	—	_____
Herpes	—	—	_____
Syphilis	—	—	_____
Urinary tract (urinary/bladder) infection	—	—	_____

Have you ever:

Had blood in your semen?	—	—	_____
Had pain after ejaculation?	—	—	_____
Had prolonged pain or swelling of testes?	—	—	_____

	Yes	No	Date
Have you:			
Developed mumps after puberty?	___	___	___
Did it cause pain in your testes?	___	___	___
Had a fever (>101°F) for more than 1 day in the past 3 months?	___	___	___

Surgical history:

Have you had any operations on the urinary tract, including the bladder or prostate?	___	___	___
Have you ever had a vasectomy?	___	___	___
Vasectomy reversal?	___	___	___
Other microsurgery for infertility?	___	___	___
Any of the following procedures:			
Hernia	___	___	___
Varicocelectomy (for enlarged veins in the scrotum)	___	___	___
Hydrocele repair	___	___	___
Testis biopsy	___	___	___
Other operations on the testis	___	___	___
Operations on the penis	___	___	___
Other Operations (describe):	___	___	___
Been told that your testes did not descend?	___	___	___
had to surgically be moved?	___	___	___

Hormonal Development & Changes:

Have you been able to smell?	___	___	___
Do you have frequent headaches?	___	___	___
Has your vision changed recently?	___	___	___
Have you had a recent change in your energy level?	___	___	___
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 more or less chest hair than other men in your family?	___	___	___

Social/Drug Exposures

Do you take long hot baths, saunas or jaccuzzis?	___	___	___
Do you smoke?	___	___	___
If so, how many packs/day?	___	___	___
Have you smoked marijuana heavily in the past?	___	___	___
How many drinks do you have in an average week?	___	___	___
Do you ever drink more than 2-3 drinks in a 24 hour period?	___	___	___
How many cups of coffee or caffeine-containing drinks do you have/day?	___	___	___
Do you currently use, or have you extensively used any of the following substances:			
Cocaine	___	___	___
LSD	___	___	___
Amphetamines	___	___	___
Heroin	___	___	___
What type of work do you do?			

Exposures (other):

Have you ever been heavily exposed to toxins, poisons, pesticides, radiation or solvents?

Sexual History:

Please rate your interest in sex: (None, minimal, moderate, intense)

How many times a week do you ejaculate? ___

How often do you masturbate(per week) ___

	Yes	No
Do you ejaculate during intercourse?	___	___
Do you ejaculate into your partner's vagina?	___	___
Have you ever been unable to achieve an erection adequate for intercourse?	___	___
Have you ever ejaculated through a soft (flaccid) penis?	___	___
Do you ever ejaculate prior to vaginal penetration?	___	___
Is intercourse ever painful for your partner?	___	___
Is her vagina ever so tight that you cannot penetrate?	___	___
Do you use any lubricant for intercourse?	___	___
If so, what lubricant: _____		
Do you frequently ejaculate into your partner's rectum?	___	___
Does your partner usually lie down for at least 30 minutes after intercourse?	___	___
Does your partner douche after intercourse?	___	___
Do you have intercourse daily or every other day when your partner is ovulating?	___	___

Family History:

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 ever given DES (diethylstilbesterol) to prevent miscarriage?	___	___
Are any of these problems present in your family:		
Birth Defects	___	___
Cystic fibrosis	___	___
Diabetes	___	___
Hormone Problems	___	___
Kidney Problems	___	___
Prostate Cancer	___	___
Tuberculosis	___	___

Other:

Please describe any other health problems you may have that Dr. Schlegel should know about:

To be completed by Dr. Schlegel

Physical Examination:

General:

Vital Signs: BP: ___/___

Heart:

Lungs:

Abdomen:

Penis:

Left Testis:

Left Vas:

Right Testis:

Right Vas:

Rectal Exam:

Summary/Assessment:

Plan:

Peter N. Schlegel, M.D.