MidLantic UROLOGY
Exceptional Care. Personal Service.

NAME:_____DOB:_____

INITIAL MALE INFERTILITY QUESTIONNAIRE

How old are you? _____How old is your spouse (partner)? _____

How many years have you been married / together? _____

How long have you been trying to achieve a pregnancy? _____ years or months

Have you ever achieved a pregnancy with your current partner? YES NO

Have you ever achieved a pregnancy with a different partner? YES NO

Has your partner ever been pregnant by a different man? YES NO

Who is your spouse / partner's gynecologist or referring physician? _____

Has your spouse / partner ever been diagnosed with any of the following?

Ovulation abnormalities	YES	NO	DON'T KNOW
Ovarian cysts	YES	NO	DON'T KNOW
Endometriosis	YES	NO	DON'T KNOW
Blocked fallopian tubes	YES	NO	DON'T KNOW

Has your spouse / partner had any of the following tests?

Blood (hormone) tests	YES	NO	DON'T KNOW
Pelvic ultrasound	YES	NO	DON'T KNOW
Hysterosalpingogram (dye test to see if tubes are open)	YES	NO	DON'T KNOW
Body temperature chart	YES	NO	DON'T KNOW
Ovulation prediction kit	YES	NO	DON'T KNOW
Laparoscopy	YES	NO	DON'T KNOW

What type of contraception did you use before attempting pregnancy (check all that apply)?

- ❒ Oral contraceptive pills
- ❒ IUD
- ❒ Condoms
- ❒ Withdrawal technique
- ❒ Rhythm method
- ❒ Diaphragm
- ❒ Spermicides / jelly
- ❒ Don't know
- ❒ None

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Have you ever had a semen analysis performed? YES NO

How many semen analyses have you had (total)? _____

At which clinic or hospital(s) was the semen analysis performed? _____

Did you have any blood tests performed? YES NO

At which hospital/office/lab was the blood work performed? _____

When you were born, were both testicles in the scrotum i.e. history of undescended testicle? YES NO

Have you ever had hernia surgery (even as a child)? YES NO Age _____

Do you smoke? YES NO If yes, how many packs/day? _____

Do you drink alcohol? YES NO If yes, how many drinks/day? _____
Drinks/week? _____

Do you use marijuana? YES NO
If yes, how many times per month? _____ In what form? _____

Do you ever use other drugs? YES NO
If yes, what type of drugs? _____

Do you use hot tubs/whirlpools/saunas on a regular basis? YES NO

Have you ever been exposed to any industrial strength chemicals or toxins? YES NO
Explain _____

Have you ever been exposed to any radiation (other than x-rays)? YES NO
Explain _____

Explain:

Have you had:

Fever >102° in the past 6 months	YES	NO
Trauma to the testicles (even as a child)?	YES	NO
Testicular torsion - a twisted testicle?	YES	NO
A varicocele (varicose vein around the testicle)?	YES	NO
Mumps?	YES	NO
Pain or swelling in a testicle (epididymitis)?	YES	NO
A sexually transmitted disease?	YES	NO
A male family member with fertility problems?	YES	NO
Prostate problems?	YES	NO
Problems with erections or sexual function?	YES	NO