Fertility questionnaire for men

Date ____________________

Name ____________________

Address ____________________

Height ____________ Weight now ____________ Greatest weight ____________

Hair color ____________ Eye color ____________

Ethnic extraction ____________________

Birthdate ____________________

Telephone number at home ____________ At work ____________

Background information

Please underline or circle all responses that apply and fill in blanks.

Rapid or marked changes in weight, increased thirst, changes in appetite, increased sweating, chronically warm or cold, painful swallowing, change of voice or hoarseness, insomnia, fatigue, tremors, salt craving, loss of hair other than on scalp, decreased beard growth, history of thyroid disease, diabetes, increase in breast size or sore nipples.

History of acquired or congenital heart disease, scarlet fever, rheumatic fever, diagnosis or treatment of high blood pressure.

History of pulmonary (lung) disease such as cystic fibrosis, tuberculosis, pneumonia, chronic bronchitis, emphysema, lung cysts or tumors.

History of liver or gall bladder disease, cirrhosis, jaundice, pancreatitis.

History of arthritis, auto-immune diseases, kidney infections or stones, gout, urinary tract abnormalities, other serious or chronic diseases.

Do you ever suspect that you have fathered a child outside this marriage? Yes No
Have you ever had reason to doubt your fertility outside this marriage? Yes No

Are you circumcised? Yes No
If no, does foreskin retract easily? Yes No
Have you ever been treated for gonorrhea, syphilis, prostatitis, or infection of testicles and/or seminal vesicles? Yes No
Has there been a recent change in libido or sexual drive? Yes No
Do you have difficulty in maintaining erection? Yes No
Do you ejaculate in vagina without difficulty? Yes No
Is urination or ejaculation painful? Yes No
Usual sexual frequency weekly (all outlets) ____________
Has a doctor ever told you that you were infertile? Yes No
Has a semen analysis ever been performed? Yes No
When? ____________ Where? ____________ Results? ____________

Has artificial insemination ever been suggested to achieve pregnancy with your sperm? Yes No
With donor sperm? Yes No
Any history of hernia repair at any age including shortly after birth? Yes No When ____________

History of mumps? Yes No Age ____________
Any history of undescended testes? Yes No
Final outcome, if yes ____________
History of injury to testes? Yes No
History or diagnosis of varicocele (varicose veins in scrotum)? Yes No Treated ____________

History of treatment in past to promote fertility? Yes No Specify ____________
History of genitourinary surgery? Yes No

Present means of employment ____________
How long has this type of work been performed? ____________ Years

Have you ever been employed in occupation with sustained high temperatures? Yes No

Have you ever been a professional driver or do you drive long distances as part of your employment? Yes No

Type of underwear worn: Boxer shorts Jockeys

Tobacco: Cigars Cigarettes Pipe Amounts daily________________

Alcohol — drinks weekly________________

Drugs

History of use of marijuana, opium or other addictive drugs: Yes No

Medications used now or recently________________

History of therapeutic x-ray treatment (not for diagnosis) or anti-cancer drugs or drugs for arthritis: Yes No

Family history:

Father	Alive	Dead	Cause ________	
	Age________			
Mother	Alive	Dead	Cause ________	
	Age________			
Sister(s)	Age(s) ________			
Brother(s)	Age(s) ________			

Any history of family infertility or endocrine disease? Yes No