FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Questionnaire for Men

General Information

Referred by: Dr.___ _____ Word of mouth [ ] Web Search [ ] Insurance [ ] Other [ ]

Name _____ **Today's Date** _____

Address

_____

_____

Telephone: Home: _____ Work: _____ Cell: _____

Birth date _____ Age _____ Ethnic Background _____

Height _____ Weight _____ Highest Education _____

Partner's Name _____ How long in this relationship? _____

Work History: Please list all recent employment, titles, brief description, and years employed:

_____ _____ _____

_____ _____ _____

Infertility History

Have you ever fathered a pregnancy? ____ yes ____ no

If yes: Year of Birth? Same Partner?

_____ _____

_____ _____

_____ _____

Have you ever been told you are infertile? ____ yes ____ no

If yes, when and by whom? _____

Length of time attempting pregnancy: ____ Years ____ Months

Length of time not using any contraceptives:

____ Years ____ Months

Did your mother take DES or other medications while pregnant with you?

_____ yes _____ no _____ don't know

If yes, list: _____

_____

_____

Sexual History

Has there been any change in your libido or sexual drive? ___ yes ___ no

Is there any difficulty in maintaining an erection? ____ yes ____ no

If yes, are you taking any medication? (Name, dose)

_____

Do you ejaculate into the vagina without difficulty? ____ yes ____ no

Do you have any pain or burning with urination or ejaculation? ___ yes ___ no

Have you ever had any discharge from the penis? ____ yes ____ no

Frequency of sexual intercourse per week? _____

Have you ever been treated for:	Dates
Genital/anal warts	_____
Syphilis	_____
Gonorrhea	_____
Chlamydia (non-specific urethritis)	_____
Prostatitis (infection of the prostate)	_____
Infection of the testicles	_____
Infection of the seminal vesicles	_____

Do you have a history of genital herpes _____yes _____no

Urologic History (if Yes, when and by whom)

Vasectomy _____

Vasectomy Reversal _____

Surgery to Correct Undescended Testicle(s) _____

_____

Varicocele Repair _____

Hernia Repair _____

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Medical/Surgery History (Past or Present)	**Yes**	**No**	**Dates/Comments**
Mumps	_____	_____	_____
Measles	_____	_____	_____
Chicken Pox	_____	_____	_____
Rubella (German Measles)	_____	_____	_____
Rheumatic fever	_____	_____	_____
Elevated Blood pressure	_____	_____	_____
Heart murmur	_____	_____	_____
Heart disease	_____	_____	_____
Diabetes	_____	_____	_____
Lung disease	_____	_____	_____
Liver or gall bladder disease	_____	_____	_____
Jaundice	_____	_____	_____
Kidney infections	_____	_____	_____
Hepatitis	_____	_____	_____
Kidney stones	_____	_____	_____
Gout	_____	_____	_____
Urinary tract abnormalities	_____	_____	_____
Thyroid disease	_____	_____	_____
Arthritis	_____	_____	_____
Auto immune diseases (lupus, rheumatoid arthritis, etc.)	_____	_____	_____

Other serious or chronic diseases
_____

Any surgery (list type and year)
_____
_____
_____

Do you have any adverse reactions to food/medications/other: Yes _____ No _____ If yes, name and type of reaction:.
_____
_____

Please list any medications you are now taking or have taken in the past. Current: _____ Past: _____

Any history of therapeutic x-ray treatment or anti-cancer drugs? Current: _____ Past: _____

Please fill in a review of any current or recent symptoms:

	Yes	No		Yes	No		Yes	No
Chronic headaches	____	____	Increased thirst	____	____	Fatigue	____	____
History of head injury	____	____	Increased sweating	____	____	Tremors	____	____
Convulsion history	____	____	Intolerance to heat	____	____	Desire for extra salt	____	____
Visual problems	____	____	Intolerance to cold	____	____	Rapid weight change	____	____
Dizziness	____	____	Difficulty sleeping	____	____	Change of appetite	____	____

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Please include any other information which you believe may be pertinent to your infertility problem _____

_____

Occupation/Leisure History	**Yes**	**No**	**Dates/Comments**
Have you ever been employed in an occupation with sustained high temperature?	_____	_____	_____
Do you drive long distances as part of your employment?	_____	_____	_____
Do you use hot tubs, saunas, etc.?	_____	_____	_____
Exposed to chemical or x-rays in work or hobby	_____	_____	_____

Please list current or past history:	**Yes**	**No**	**Amount per day or week**
Caffeine	_____	_____	_____
Smoking	_____	_____	_____
Alcohol	_____	_____	_____
Marijuana	_____	_____	_____
Drugs (not prescribed), list	_____	_____	_____
Herbs/supplements	_____	_____	_____
Performance-enhancing drugs	_____	_____	_____

Please describe recreational/sports activities (frequency, length of time, etc.) _____

_____

Family History

Father's age if alive _____ If no longer living, cause of death and age _____

Medical problems: _____# of biologic children: _____

Mother's age if alive _____ If no longer living, cause of death and age _____ _____

Medical problems: _____ # of biologic children: _____

Sister(s): Age: _____ Medical problems: _____

Age: _____ Medical problems: _____

Age: _____ Medical problems: _____

Brother(s): Age: _____ Medical problems: _____

Age: _____ Medical problems: _____

Age: _____ Medical problems: _____

Is there a family history of:	**Yes**	**No**	**Comments**
Birth defect	_____	_____	_____
Mental Retardation	_____	_____	_____
Genetic diseases	_____	_____	_____
Infertility	_____	_____	_____
Hormone problems	_____	_____	_____
Miscarriages/stillbirths	_____	_____	_____
Pregnancy problems	_____	_____	_____
Cancer: Breast Prostate Ovarian Colon	_____	_____	_____
Stroke	_____	_____	_____
Heart disease	_____	_____	_____
Lung disease	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid/endocrine problems	_____	_____	_____
High blood pressure	_____	_____	_____
Any women who have never menstruated	_____	_____	_____
Any men who have never had to shave	_____	_____	_____

FAMILY FERTILITY CENTER **www.familyfertility.com**
H. Christina Lee, M.D., J.D., H.C.L.D., F.A.C.O.G. **Medical and Laboratory Director**
95 Highland Avenue, #100 Telephone (610) 868-8600
Bethlehem, PA 18017 Fax (610) 868-8700

Any additional comments you would like to make that you feel may be pertinent and have not already been addressed:

_____

_____

Pre-conceptual Health Screening

Have you ever been tested for:	Yes	No	If yes, give dates/results
Hepatitis B	☐	☐	_____
HIV (AIDS)	☐	☐	_____
Rubella	☐	☐	_____
TB (Tuberculosis)	☐	☐	_____
Blood Type	☐	☐	_____
Tay-Sachs	☐	☐	_____
Gaucher Disease	☐	☐	_____
Canavan Disease	☐	☐	_____
Cystic Fibrosis	☐	☐	_____
Sickle cell	☐	☐	_____
Diabetes	☐	☐	_____
Thalassemia	☐	☐	_____

Previous Infertility Testing

Previous urological exam? ☐ yes ☐ no

Results: _____

Previous semen analysis? ☐ yes ☐ no

Results:	Date	Count (million/cc)	Motility (% moving)	Morphology (% normal shape)
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Specialized sperm testing? ☐ yes ☐ no
(Acrosome reaction, sperm penetrating assay, antibody testing)

Results (which tests): _____

Specific treatment for Male Infertility? ☐ yes ☐ no

Details: _____

_____

Patient Signature: _____ **Date:** _____