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 ______________________________________

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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	____	____

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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	_____	_____	______________________

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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:** ______________