Vasectomy and Male infertility Center of Connecticut

Male Fertility Questionnaire

Name: _____

Date: _____

Primary MD: _____

Referring MD: _____

How you heard about Dr. Matson:

Doctor Friend Radio Internet Wife

Please list all medical conditions:

None

1. _____
2. _____
3. _____
4. _____

Please list all medications taken daily:

None

1. _____
2. _____
3. _____
4. _____

Please list all surgeries you have had:

None

1. _____ Date_____
2. _____ Date_____
3. _____ Date_____
4. _____ Date_____

Please list family illnesses and relationship:

None

1. _____Relative_____
2. _____Relative_____
3. _____Relative_____
4. _____Relative_____

Please list all allergic triggers and reaction:

None

1. _____Reaction_____
2. _____Reaction_____
3. _____Reaction_____

Current type of work/profession:

_____

Marital status:

Single Married Divorced Remarried

Fertility History

How many months have you and your current partner been trying to achieve a pregnancy? _____

How old is your partner? _____

Have you achieved pregnancy with your current partner in the past (circle)? N Y

If yes give outcome and date.

1. _____ Date_____
2. _____ Date_____
3. _____ Date_____
4. _____ Date_____

Has your partner been evaluated for infertility?

N Y (outcome_____)

Have your or your partner ever had sterilization?

N Y (details_____)

Have you achieved pregnancy with any other partners?

N Y (details_____)

Has your partner had pregnancies with someone other than you?

N Y (details_____)

Sexual History

Rate your level of desire (circle):

←----very low---low---medium---high---very high----→

How many times per week do you have intercourse? _____

Do you ejaculate with intercourse? Y N

Do you ejaculate in your partner's vagina? Y N

How many times per week do you ejaculate? _____

How many times per week do you masturbate? _____

Do you have trouble getting or maintaining erection? Y N

Have you ever ejaculated with a flaccid (soft) penis? Y N

Do you ejaculate prior to penetration?
Y N

Is intercourse painful for you? Y N

Do you use lubrication for intercourse (name)? _____

Partners Sexual History

Rate your partners level of desire (circle):

←----very low---low---medium---high---very high----→

Does your partner get up after intercourse? _____

Does your partner experience pain with intercourse? Y N

Does your partner have regular menstrual periods? Y N

Has your partner or you learned to predict ovulation? Y N

Do you have sex every other day during ovulation? Y N

Has your partner ever had abdominal surgery?
Y N

Has your partner ever had:

Herpes Y N

Gonorrhea Y N

Pelvic Inflammatory Disease Y N

Chlamydia Y N

Specific Medical History:

Have you ever had the following conditions?

Arthritis Y N Age _____

Bowel Disorder Y N Age _____

Cancer Y N Age _____

Change in body appearance? Y N Age _____

Color Blindness Y N Age _____

Deafness Y N Age _____

Diabetes Y N Age _____

Heart Problems Y N Age _____

Hepatitis/Liver problems Y N Age _____

High Blood Pressure Y N Age _____

Indigestion/Ulcer Y N Age_____

Spinal disc/cord Problems Y N Age _____

Lung or Breathing Problems Y N Age _____

Thyroid Disease Y N Age _____

Neurologic Disorder Y N Age _____

Sickle Cell Disease Y N Age _____

Sinus Problems Y N Age _____

Tuberculosis Y N Age _____

Fever > 101 in the past 3 months?
Y N

Have you ever taken the following medications?

Allopurinol Y N When? _____

Antidepressants Y N When? _____

Antihypertensives Y N When? _____

Anti-parasitic agents Y N When? _____

Antipsychotics Y N When? _____

Cholesterol drugs Y N When? _____

Clomid Y N When? _____

Dilantin Y N When? _____

hCG injections Y N When? _____

Hormones Y N When? _____

Immunosuppressants Y N When? _____

Insulin Y N When? _____

Proscar or Propecia Y N When? _____

Tagamet (cimetidine) Y N When? _____

Zantac Y N When? _____

Specific Surgical History:

Have you ever had surgery for the following?

Hernia Y N

Varicocele Y N

Hydrocele Y N

Prostate problems Y N

Undescended testicle Y N

Abdominal surgery Y N

Testicle problem Y N

Vasectomy Y N

Vasectomy reversal Y N

Penis surgery Y N

Prostate problems Y N

Specific Urologic History:

Have you ever had?

Infection or swelling of the testicle Y N

Infection of the prostate Y N

Infection of the epididymis Y N

Gonorrhea Y N

Chlamydia Y N

Syphilis Y N

Herpes Y N

Herpes Y N

Mumps Y N

Had blood in the semen Y N

Pain with ejaculation Y N

Pain or swelling of the testicle Y N

White, green or yellow urethral discharge Y N

Endocrine History

Have you ever had?

Difficulty smelling Y N

Headaches Y N

Visual problems Y N

Change in energy level Y N

Poor sense of well being Y N

At what age did you develop armpit hair? _____

At what age did you develop pubic hair? _____

At what age did you start shaving your face? _____

How often do you shave (circle)?

Twice per day Once per day Twice per day

Social History

Do you smoke? Y N How long? _____

How many cigarettes per day? _____

Do you use marijuana? Y N How long? _____

How many marijuana cigarettes per day? _____

Do you use alcohol? Y N

How many drinks per week? _____

More than 2-3 drinks in a 24-hour period? Y N

Do you use any of the following?

Cocaine Y N How long? _____

LSD Y N How long? _____

Amphetamines Y N How long? _____

Heroine Y N How long? _____

Methadone Y N How long? _____

Do you use saunas or hot tubs regularly? Y N

Do you use a laptop on your lap regularly? Y N

Have you had exposures to the following substances?

Prolonged heat Y N

Radiation Y N

Pesticides Y N

Solvents Y N

Heavy metals Y N

Toxins Y N

Family History

How many brothers do you have? _____

How many children do they have?

Brother #1_____ Brother #2_____

Brother #3 _____ Brother #4_____

Any have known fertility problems? Y N

How many sisters do you have? _____

How many children do they have?

Sister #1_____ Sister #2_____

Sister #3 _____ Sister #4_____

Any have known fertility problems? Y N

Was your mother given DES during pregnancy? Y N

Is there a family history of the following illnesses?

Birth defects? Y N

Cystic fibrosis Y N

Diabetes Y N

Hormone problems Y N

Kidney problems Y N

Lung disease Y N

Tuberculosis Y N

Other – Please use the space below to describe any other information or problems you feel Dr. Matson should know about.