

Name: _____

Date: _____

FERTILITY EVALUATION QUESTIONNAIRE

In order to understand the exact nature of your problem, we ask that you complete the questionnaire.

In your own words, explain your concern or problem with fertility:

Please answer the following questions by circling or underlying your response. Feel free to add information that you feel is important.

MARITAL HISTORY

How long have you been married? _____

How long have you been actively trying to have a baby? _____

Wife's obstetrician _____

Is there any fertility problems with your wife? _____

Wife's age? _____ Previous pregnancies? _____

CHILDHOOD

Do you have a history of:

Undesended testes	Y	N
Other surgery on your testicles	Y	N
Mumps	Y	N
Bladder/Urinary passage surgery	Y	N
Hernia surgery	Y	N
Other _____		

MEDICAL HISTORY

Diabetes	Y	N
Multiple Sclerosis	Y	N
Injury to pelvic or scrotum	Y	N
Surgery to the pelvis, testicles or bladder	Y	N
Other surgery or medical problems _____		

CURRENT & PAST MEDICATIONS/DRUGS

Prescription drugs	Y	N
Steroids or body building drugs	Y	N
Chemotherapy	Y	N
Recreational Drugs	Y	N
Cimetidine	Y	N
Antibiotics	Y	N

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CURRENT & PAST MEDICATIONS/DRUGS CONTINUED**Tobacco**

Have you ever smoked? Yes No Presently smoking: Yes No
If yes, how long? _____ If quit, when? _____
How much: Daily _____ Weekly _____

Alcohol

Beer _____ Wine _____ Liquor _____
Presently _____ In the Past _____
How much: Daily _____ Weekly _____

ENVIRONMENTAL HISTORY

Current Occupation _____
Past or present exposure to:
Radiation _____
Chemicals _____
Known Pollutants _____
Thermal exposure (extreme or excessive heat):
Occupational _____ Hot Tubs _____ Other _____

SEXUAL ACTIVITY/HISTORY

Average sexual intercourse: _____ Week _____ Month
Other: _____
Have you ever fathered a child or been responsible for conception?

Have you had a vasectomy reversal?

ERECTILE DYSFUNCTION

Do you have:

Failure to achieve erection	Y	N
Failure to maintain an erection	Y	N
Failure to ejaculate/achieve orgasm	Y	N
Decreased desire/no drive for sex	Y	N
Other _____		