

Andrology Male Infertility Questionnaire

WE WOULD ASK THAT YOU PLEASE FILL IN THE FOLLOWING QUESTIONNAIRE AS COMPLETELY AND ACCURATELY AS POSSIBLE BEFORE YOU SEE THE MALE FERTILITY SPECIALIST. ALL PROVIDED INFORMATION WILL REMAIN CONFIDENTIAL. IT WILL BE RELEASED ONLY WITH YOUR WRITTEN PERMISSION AND WILL BE USED TO HELP US TREAT YOU.

Dr. James M. Hotaling | Dr. Alex Pastuszak

UTAH MEN'S HEALTH | AHEAD OF THE CURVE

5126 DAYBREAK PARKWAY, SOUTH JORDAN, UT 84009

FAX: 801-581-6127

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

Current Partner History

*Pregnancy with current partner?

Yes No

If yes, did pregnancy result in a child?

Yes No

If yes, children's ages.

*How many years have you had unprotected sex not resulting in pregnancy?

*How often do you have sex per month?

Ejaculation Painful?

Yes No

*Semen Color

White Yellow Brown Red

*More semen when younger?

Yes No

*Erection problems?

No Sometimes Mostly Always

*Urination painful after sex?

Yes No

*Urine cloudy after sex?

Yes No

*Contraception

Never used Birth control pill Intrauterine device Condom
Diaphragm Other

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

Date when contraception last used.

***Sexual Aids**

Yes No

If yes, what type?

***Sexual lubricants**

Yes No

If yes, what type?

Previous Partner Pregnancy History

Pregnancy with a previous partner?

Yes No

If yes, did pregnancy result in a child?

Yes No

If yes, children's ages.

Previous Infertility Treatment

***Antibiotics**

Yes No

If yes, date and type of treatment

***Hormones**

Yes No

If yes, date and type of treatment

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

***Clomid**

Yes No

If yes, date and type of treatment

***Letrazole or arimidex**

Yes No

If yes, date and type of treatment

***HCG**

Yes No

If yes, date and type of treatment

***FSH (puregon, pergonal)**

Yes No

If yes, date and type of treatment

***Other Infertility Treatment**

Yes No

If yes, date and type of treatment

Other Treatments

INSTRUCTIONS: Are you presently taking or taken within the last 6 months?

***Antibiotics**

Yes No

***Testosterone or anabolic (body building) steroids**

Yes No

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

If yes, prescribed by

Family Doctor

Urologist

Endocrinologist

Other Doctor

Nonprescription (from friends or acquaintances)

If yes, why are you taking the Testosterone/anabolic steroids?

Low sex drive

Low testosterone found by my doctors

Poor energy

Improve athletic ability

Improve looks

Propecia or finasteride

Other

Additional History

* Developed body hair at age?

* Used baths, saunas, whirlpools in the past 6 months?

Yes

No

* Exposed to chemicals, pesticides, or radiation?

Yes

No

* If yes, exposure type

* other exposure?

Yes

No

* If yes, other type

Female Partner General Information

Name (Last name, First name)

Date of Birth

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

Gynecologist/REI work up?

Yes No

If yes, by Doctor

Pregnancy with a previous partner?

Yes No

If yes, did pregnancy result in a child?

Yes No

If yes, children's ages

Age of first menstruation

Average menstrual cycle duration (days)

Average period duration (days)

Periods regular?

Yes No

Medications used in the last six months

Have you been diagnosed with Endometriosis?

Yes No

Have you been diagnosed with Fallopian Tube Obstruction?

Yes No

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

Female Partner Recent Fertility Medications

INSTRUCTIONS: Please select all that apply and enter the start and stop dates for each medication selected.

Testosterone

Yes

No

Start Date

Stop Date

Clomid

Yes

No

Start Date

Stop Date

HCG

Yes

No

Start Date

Stop Date

R-FSH

Yes

No

Start Date

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

Stop Date

Anastrozole/letrozole

Yes No

Start Date

Stop Date

Cabergoline

Yes No

Start Date

Stop Date

Female Partner Gynecological Surgical History

Laparoscopy

Yes No

If yes, date of surgery

Scrape Uterus

Yes No

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

If yes, date of surgery

Operation on Cervix

Yes No

If yes, date of surgery

Remove Ovary

Left Right Both

If yes, date of surgery

Remove Tube

Left Right Both

If yes, date of surgery

Repair Tube

Left Right Both

If yes, date of surgery

Other Surgery

Yes No

If yes, name and date of surgery

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

Female Partner Infection History

Gonorrhea

Yes

No

If yes, date and type of treatment

Syphilis

Yes

No

If yes, date and type of treatment

Herpes

Yes

No

If yes, date and type of treatment

Genital warts

Yes

No

If yes, date and type of treatment

Chlamydia

Yes

No

If yes, date and type of treatment

UTAH MEN'S HEALTH | Ahead of the Curve

Andrology Male Infertility Questionnaire

* Indicates a required field.

Bladder

Yes

No

If yes, date and type of treatment

Kidney

Yes

No

If yes, date and type of treatment

Cervical

Yes

No

If yes, date and type of treatment

Other infection

Yes

No

If yes, date and type of treatment
