Vasectomy and Male Infertility Center of Connecticut

Male Fertility Questionnaire

Name: _____

Today's Date: _____

Primary MD: _____

Referring MD: _____

Pharmacy& Address: _____

Partners' Full Name:_____

Partners' DOB:_____

Partner's OB/GYN: _____

How you heard about Dr. Matson:

Doctor Friend Radio Internet Wife

Height_____ **Weight**_____

Please list all medical conditions:

None

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

Please list all medications taken daily:

None

1. _____
2. _____
3. _____

Please list all surgeries you have had:

None

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

Current type of work/profession:

_____

Marital status:

Single Married Divorced Remarried

Male Patient's Fertility History

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

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

Have you achieved pregnancy with any other partner in the past (circle)? N Y

If yes to pregnancies 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_____)

Male Partner's 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? _____

Do you have trouble getting or maintaining erection? Y N

Do you ejaculate prior to penetration? Y N

Is intercourse painful for you? Y N

Do you use lubrication for intercourse (name)? _____

Female Partner's Sexual History

Rate your partners level of desire (circle):

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

Does your partner experience pain with intercourse? Y N

Does your partner have regular menstrual periods? Y N

Has your partner 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

Other Specific Medical History for Male Partner:

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/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 _____
Mumps	Y	N	Age _____
Fever in the past 3 months?	Y	N	

Have you ever taken the following medications?

Allopurinol	Y	N	When? _____
Antidepressants	Y	N	When? _____
Antihypertensive	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? _____
Testosterone	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? _____

Male Partner's 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

Male Partner's Specific Urologic History:

Have you ever had?

Pain 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

Male Parner's Endocrine History

Have you ever had?

Difficulty smelling Y N

Recurring 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 pubic hair? _____

At what age did you start shaving your face? _____

How often do you shave? _____

Male Partner's 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 vape? 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? _____

Narcotics 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?

Prolonged heat Y N

Radiation Y N

Pesticides Y N

Solvents Y N

Heavy metals Y N

Toxins Y N

Male Partner's 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.