Infertility Questionnaire

The following questionnaire is designed to help your physician evaluate your infertility. Please circle or fill in the appropriate answer. If you have any questions or additional comments, write them in the space provided.

A. General Information

1. Date: ____________________________  Phone #: (______) __________________

2. Your Name: ____________________________  Age: ______

3. Wife’s/Partner’s Name: ____________________________  Age: ______

4. Your Occupation: ________________________________________

5. Wife’s/Partner’s Occupation: ______________________________

B. Fertility History

1. Are you currently married or in a relationship?  Yes  No

2. If yes, what is the duration of your current marriage/relationship? ________________________

3. How long have you been attempting to initiate a pregnancy? ________________________

4. Have you been involved in any previous pregnancies in this relationship?  Yes  No
   If yes:  Age(s) __________________________________________
   Gender(s) __________________________________________
   Any difficulties initiating these pregnancies? ________________________

5. Have you been involved in previous pregnancies in any other relationships?  Yes  No
   If yes:  Age(s) __________________________________________
   Gender(s) __________________________________________
   Any difficulties initiating these pregnancies? ________________________

6. Have you been previously evaluated or treated for infertility?  Yes  No
   If yes:  When: __________________________________________
   By whom: __________________________________________
   What treatment was performed? __________________________________________
7. Has your wife/partner been evaluated for infertility? Yes No
   If yes: When: ____________________________
   By whom: ____________________________
   What tests have been performed? BBT, ultrasound, hysterosalpingogram, endometrial biopsy, post-coital test, laparoscopy

C. **Sexual History**

1. Do you have any problems with erection? Yes No
   If yes: initiation, rigidity, curvature, duration, premature ejaculation
2. Any lubricants used during intercourse? Yes No
   If yes, what kind? ____________________________
3. Are you timing intercourse with ovulation? Yes No
4. How frequently do you have intercourse? ____________________________

D. **Childhood**

1. At what age was the onset of puberty? ________________
2. As a child did you have:
   a) Undescended testicles Yes No
      If yes, what side? Right Left
   b) Testicular torsion Yes No
   c) Hernia surgery Yes No
   d) Mumps Yes No
      If yes, did involve testicles? Yes No
      Did it occur after puberty? Yes No
   e) Bladder surgery Yes No
   f) Hypospadias surgery Yes No

E. **Medical History**

1. Do you have any medical problems? Yes No
   If yes, what are they? __________________________________________

2. Do you take any medication? Yes No
If yes, what are they? __________________________________________

3. Are you allergic to any medications?  Yes  No

   If yes, what are they? __________________________________________

4. Have you ever been diagnosed with low testosterone?  Yes  No

5. Have you ever taken testosterone?  Yes  No  If yes, when:__________________

F. Surgical History

1. Have you had any previous operations?  Yes  No

   If yes, what was performed? __________________________________________

G. Infections

1. Have you had any previous infections of the following-
   (If yes, please list dates and describe treatment below)
   a) Kidneys________________________Yes  No
   b) Prostate________________________Yes  No
   c) Testicles________________________Yes  No
   d) Epididymis_______________________Yes  No
   e) Urethra__________________________Yes  No

H. Exposure

1. Have you had any exposure in the last six months to-
   a) Pesticides                  Yes  No
   b) Chemotherapy              Yes  No
   c) Anabolic Steroids         Yes  No
   d) High Temperatures         Yes  No
   e) X-Rays                    Yes  No

I. Social History

1. Do you consume alcohol?  Yes  No

   If yes, how much per week? __________________________
2. Do you presently smoke or have you ever smoked:
   a) Cigarettes  
      Yes  
      No  
      Amount per day________________
   b) Marijuana  
      Yes  
      No  
      Amount per day________________

J. Family History

1. Does anyone in your family have a history of-
   (Please state your relationship with that person as well)
   a) Infertility  
      Yes  
      No  
      Relationship______________________________
   b) Cystic Fibrosis  
      Yes  
      No  
      Relationship______________________________
   c) Hormonal Imbalance  
      Yes  
      No  
      Relationship______________________________

K. Current Personal Problems

1. Do you have, or have you had, problems with:
   a) Chronic Respiratory Infection  
      Yes  
      No  
   b) Loss of sense of smell  
      Yes  
      No  