IDAHO UROLOGIC INSTITUTE

Main: (208) 639-4900
Fax: (208) 639-4901
www.idurology.com

Infertility Questionnaire

The following questionnaire is designed to help your physician evaluate your infertility. Please
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