URC
Male Infertility Questionnaire

Name: _____ **Date of Birth**: _____
Partner's Name: _____ **Today's Date**: _____

What is your ancestry?

☐ African-American
☐ American Indian/Native American
☐ Ashkenazi Jewish
☐ Asian-American
☐ Cajun/French Canadian
☐ Caucasian
☐ Eastern European
☐ Hispanic/Caribbean
☐ Northern European
☐ Southern European
☐ Other (specify _____)

How would you describe your religious beliefs?

☐ Catholic
☐ Christian
☐ Jewish
☐ Muslim
☐ Islam
☐ Buddhist
☐ Hindu
☐ Other (specify _____)

What best describes your personal life?

☐ Single
☐ Living with partner
☐ Married/Domestic partnership
☐ Separated
☐ Divorced
☐ Widowed
☐ Other (specify _____)

What is your country of birth? _____

Fertility History

How long have you and your partner been trying to conceive with unprotected intercourse? ____ months ____ years

Have you had a pregnancy with your current partner?
☐ No ☐ Yes –
How many pregnancies? ____

Year	Outcome (circle one)
____	Delivery / miscarriage / ectopic
____	Delivery / miscarriage / ectopic
____	Delivery / miscarriage / ectopic

Have you had a pregnancy with another partner?
☐ No ☐ Yes –
How many pregnancies? ____

Year	Outcome (circle one)
____	Delivery / miscarriage / ectopic
____	Delivery / miscarriage / ectopic
____	Delivery / miscarriage / ectopic

Had your current partner ever been pregnant with another partner?
☐ No ☐ Yes –
How many pregnancies? ____

Year	Outcome (circle one)
____	Delivery / miscarriage / ectopic
____	Delivery / miscarriage / ectopic
____	Delivery / miscarriage / ectopic

Have you ever had any types of fertility problems? ☐ No ☐ Yes – please explain:

_____

_____

Have you ever taken any fertility medications? ☐ No ☐ Yes – what kinds?

Clomid ☐ No ☐ Yes For how long? _____
Hormone injections ☐ No ☐ Yes For how long? _____
Other ☐ No ☐ Yes For how long? _____

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URC MALE INFERTILITY HISTORY

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REV JUL 09

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Male Infertility Questionnaire

Medical History

Have you had a recent (within the past year) illness with a fever of 101°F?
☐ No ☐ Yes - how long did the fever last, and what was the cause (if known?)
_____

	Type	Check One	If yes, when?
Did you have any of the following childhood infections?	Chicken pox	☐ No ☐ Yes	_____
	Measles	☐ No ☐ Yes	_____
	Mumps	☐ No ☐ Yes	_____
	Other	☐ No ☐ Yes	_____

Have you ever taken any of the following medications?

Name of Medication	Check One
Selective Serotonin Reuptake inhibitors (SSRIs) (i.e. Prozac, Zoloft, Lexapro, Celexa, Paxil)	☐ No ☐ Yes
Other antidepressant, names: _____	☐ No ☐ Yes
Other psychiatric drugs, names: _____	☐ No ☐ Yes
Beta-blockers (i.e. Tenormin, Lopressor, Trandate)	☐ No ☐ Yes
Calcium-channel blockers (i.e. nifedipine, verapamil, cardizem)	☐ No ☐ Yes
Other antihypertensive drugs (blood pressure medicine), names: _____	☐ No ☐ Yes
Steroids (i.e. prednisone, medrol)	☐ No ☐ Yes
Other immunosuppressant drugs, names: _____	☐ No ☐ Yes
Insulin	☐ No ☐ Yes
Tagamet (cimetidine)	☐ No ☐ Yes
Zantec (rantidine)	☐ No ☐ Yes
Zovirax (acyclovir)	☐ No ☐ Yes
Propecia, for how long? _____	☐ No ☐ Yes
Minoxidil, for how long? _____	☐ No ☐ Yes
Finasteride, for how long? _____	☐ No ☐ Yes

Have you ever been diagnosed with any of the following?

Type	Check One	If yes, since when?
Thyroid disease	☐ No ☐ Yes	_____/_____
Sickle cell disease	☐ No ☐ Yes	_____/_____
Color blindness	☐ No ☐ Yes	_____/_____
Tuberculosis	☐ No ☐ Yes	_____/_____
Heart problems describe: _____	☐ No ☐ Yes	_____/_____
Diabetes	☐ No ☐ Yes	_____/_____
High blood pressure	☐ No ☐ Yes	_____/_____

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URC MALE INFERTILITY HISTORY

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Male Infertility Questionnaire

What medications do you take on a regular basis?

Name: _____ How long? _____ How often? _____
Name: _____ How long? _____ How often? _____
Name: _____ How long? _____ How often? _____
Name: _____ How long? _____ How often? _____

Recent Problems

For each item below, please show whether you have had any recent problems by checking yes or no:

	Yes	No
General:		
Weight change without trying	☐	☐
Unusual fatigue	☐	☐
Fevers	☐	☐
Lost of appetite	☐	☐
Awakening due to pain	☐	☐
Head/eyes/ears/throat:		
Changes in your eyesight	☐	☐
Hoarse voice	☐	☐
Difficulty swallowing	☐	☐
Difficulty hearing	☐	☐
Bleeding from gums	☐	☐
Heart:		
Palpitation	☐	☐
Chest pain	☐	☐
High blood pressure	☐	☐
Lungs:		
Shortness of breath	☐	☐
Cough	☐	☐
Coughing up blood	☐	☐
Wheezing	☐	☐

	Yes	No
Intestinal:		
Blood in stool	☐	☐
Constipation	☐	☐
Abdominal pain	☐	☐
Abdominal bloating	☐	☐
Diarrhea	☐	☐
Glands/lumps:		
Swollen lymph nodes	☐	☐
Lump or mass elsewhere	☐	☐
_____ (describe/location)		
Skin:		
Non-healing sore(s)	☐	☐
Changing mole(s)	☐	☐
Joints, bones, and muscles:		
Muscle or bone pain	☐	☐
Painful joints	☐	☐
Swollen ankles	☐	☐

	Yes	No
Neurologic/psychiatric:		
Loss of memory	☐	☐
Weakness in limbs	☐	☐
Dizziness or passing out	☐	☐
Numbness or tingling	☐	☐
Anxiety or panic attacks	☐	☐
Depression or blue moods	☐	☐
Endocrine:		
Thirsty all the time	☐	☐
Can't stand heat or cold	☐	☐

Do you have any other health concerns that your provider should know about today? ☐ ☐

If yes, please explain:

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URC MALE INFERTILITY HISTORY

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Male Infertility Questionnaire

Male History

Have you had any of the following sexually transmitted diseases or pelvic infections? ☐ Yes *(check all that apply)* ☐ No

☐ Chlamydia – date: ___/___ ☐ Gonorrhea – date: ___/___ ☐ Herpes – date: ___/___
☐ Genital warts/HPV – date: ___/___ ☐ Syphilis – date: ___/___ ☐ HIV/AIDS – date: ___/___
☐ Hepatitis – date: ___/___ ☐ Other – date: ___/___

Have you ever had an infection involving: ☐ Yes *(check all that apply)* ☐ No

☐ Prostate (or prostatitis) – date: ___/___ ☐ Epididymis – date: ___/___ ☐ Testes – date: ___/___
☐ Urethra – date: ___/___ ☐ Urinary tract or bladder – date: ___/___

Have you ever had any of these conditions? ☐ Yes *(check all that apply)* ☐ No

☐ Blood in your semen – date: ___/___ ☐ Pain after ejaculation – date: ___/___
☐ Prolonged pain/swelling of your testes – date: ___/___

Have you ever experience major trauma to your testes? ☐ No ☐ Yes – please explain:
_____
_____

Question	Check One:	Which Side? (*Circle One*)	When?
Have you ever been told that your testes did not descend?	☐ No ☐ Yes	Right Left Both	_____/_____
Have your testes been surgically brought down to your scrotum?	☐ No ☐ Yes	Right Left Both	_____/_____
Have you had a testicle removed?	☐ No ☐ Yes	Right Left Both	_____/_____
Have you ever had a hernia repair?	☐ No ☐ Yes	Right Left Both	_____/_____
When you were younger did your testes ever twist?	☐ No ☐ Yes	Right Left Both	_____/_____
Was surgery ever done to untwist your testes?	☐ No ☐ Yes	Right Left Both	_____/_____
Have you ever been diagnosed with hypospadias (urethral opening is along the penile shaft rather than at the tip)?	☐ No ☐ Yes		_____/_____
Have you ever had a vasectomy?	☐ No ☐ Yes		_____/_____
Have you ever had a vasectomy reversal?	☐ No ☐ Yes		_____/_____
Have you ever had a hydrocele repair?	☐ No ☐ Yes	Right Left Both	_____/_____
Have you ever had a varicocele repair?	☐ No ☐ Yes	Right Left Both	_____/_____
Have you had any other surgery on your scrotum or testicle? Please describe: _____	☐ No ☐ Yes	Right Left Both	_____/_____

Sexual History

How often do you have intercourse? _____ per week / _____ per month
How often do you have any sexual activity? _____ per week / _____ per month
How often do you ejaculate? _____ per week / _____ per month
How often do you masturbate? _____ per week / _____ per month
How often do you take hot baths, saunas, or jacuzzis? _____ per week / _____ per month
Have you had any problems with erections? ☐ No ☐ Yes

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URC MALE INFERTILITY HISTORY

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Male Infertility Questionnaire

In the past 6 months,			**Please check one:**		
How do you rate your confidence that you could get and keep an erection?	☐ Very Low	☐ Low	☐ Moderate	☐ High	☐ Very High
When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
During sexual intercourse, how often do you maintain your erection to completion of intercourse?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	☐ Extremely difficult	☐ Very difficult	☐ Difficult	☐ Slightly difficult	☐ Not difficult
When you attempted sexual intercourse, how often was it satisfactory for you?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always

Currently,			**Please check one:**		
Do you ejaculate during intercourse?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Do you ejaculate into your partner's vagina?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Have you ever been unable to achieve an erection adequate for intercourse?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Have you ever ejaculated through a soft (flaccid) penis?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Do you ever ejaculate prior to vaginal penetration?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Is intercourse ever painful for your partner?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Is intercourse ever painful for you?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Is her vagina ever so tight that you cannot penetrate?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Do you use lubricant? If yes, what lubricant? _____	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Do you frequently ejaculate in your partner's rectum?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Does your partner douche after intercourse?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always
Do you have intercourse daily or every other day when your partner is ovulating?	☐ Almost never/Never	☐ A few times (less than half)	☐ Sometimes (about half)	☐ Most of time (more than half)	☐ Almost always/Always

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Male Infertility Questionnaire

How interested are you in sex? Please circle one: (not interested) 1 2 3 4 5 6 7 8 9 10 (very interested)

Occupational History

What type of work do you do? _____
Since when? _____/_____ (month/year)
At work, are you exposed to chemicals or pesticides? ☐ No ☐ Yes – what type? _____
Since when? _____/_____ (month/year)
At work, are you exposed to radiation? ☐ No ☐ Yes – how? _____
Since when? _____/_____ (month/year)

Cancer History

Have you ever had treatment for cancer? ☐ No ☐ Yes – what types? _____
When? _____/_____ (month/year)
Have you ever had chemotherapy? ☐ No ☐ Yes – what type(s)? _____
When? _____/_____ (month/year)
Have you ever had radiation treatment? ☐ No ☐ Yes – if yes, was it directed to pelvis? ☐ No ☐ Yes
Have you ever had lymph nodes removed from your penis or retroperitoneum? ☐ No ☐ Yes

Habits

Do you currently smoke cigarettes? ☐ No ☐ Yes – how many per day? __ for how many years? __
Did you smoke at one time in your life, but quit smoking? ☐ No ☐ Yes – how many per day? __ for how many years? __

In the past 6 months,	**Check one:**	**How often?**	**What kind?**
Have you used marijuana? If yes, when was the last time? _____	☐ No ☐ Yes	_____ per week	
Did you drink coffee or caffeinated beverages?	☐ No ☐ Yes	_____ per week	_____
Did you drink alcoholic beverages?	☐ No ☐ Yes	_____ per week	_____
Have you ever used any other drugs?	☐ No ☐ Yes	_____ per week	_____

Have you ever taken any of the following male enhancers? Check one:		**When?**	**For how long?**
Maxoderm	☐ No ☐ Yes	_____	____ weeks/____ months
Enzyte	☐ No ☐ Yes	_____	____ weeks/____ months
Stamina Rx	☐ No ☐ Yes	_____	____ weeks/____ months
Libido-Max	☐ No ☐ Yes	_____	____ weeks/____ months
Vazozyme	☐ No ☐ Yes	_____	____ weeks/____ months
Ogo-plex	☐ No ☐ Yes	_____	____ weeks/____ months
Extagen	☐ No ☐ Yes	_____	____ weeks/____ months
Black Pearl	☐ No ☐ Yes	_____	____ weeks/____ months
Other: _____	☐ No ☐ Yes	_____	____ weeks/____ months

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Have you ever used any of the following anabolic steroids or body-building supplements?	Check one:	How often?	For how long?
DHEA	☐ No ☐ Yes		____weeks/____months
Testosterone If yes, please circle all that were used: *Injectable forms*: Testosterone (Malogen, Malogex, Delatestryl, Testoject) Testosterone cypionate (Depo-testosterone, Textex) Testosterone enanthate (Delatestryl) Nandrolone (Deca-Durabolin, Durabolin, Kabolin, Nandrobolic) *Oral forms*: Oxandrololone (Anavar) Oxymetholone (Andadrol, Anapolon 50, Androyd) Fluoxymesterone (Halostestin, Ora-Testryl, Ultradren) Methyltestosterone (Android, Estratest, Testred, Virilon)	☐ No ☐ Yes		____weeks/____months
Dihydrotestosterone (Stanolone)	☐ No ☐ Yes		____weeks/____months
Methandrostenolone (Dianobol)	☐ No ☐ Yes		____weeks/____months
Other Testosterones If yes, please circle all that were used: Bolasterone (Vebonol) Clostebol (Steranobol) Dehydrochlormethyl-testosterone (Turinabol) Dihydrotestosterone (Stanalone) Mesterolone (Androviron, Proviron) Metandienone/Methandrostenolone (Danabol, Dianabol, Dianobol) Methenolone (Primobolan, Promonabol-Depot) Norethandrolone (Nilevar)	☐ No ☐ Yes		____weeks/____months
Mass System Nitro T3	☐ No ☐ Yes		____weeks/____months
Tribex	☐ No ☐ Yes		____weeks/____months
Vitrix	☐ No ☐ Yes		____weeks/____months
Universal Animal Stak2	☐ No ☐ Yes		____weeks/____months
Secretagogue-One	☐ No ☐ Yes		____weeks/____months
Tribulus Terrestris If yes, circle all that were used: Universal Animal Stak2 MHP T-bomb Optimum Tribulus, BNS Axis HT Goliath Labs Ejaculoid	☐ No ☐ Yes		____weeks/____months
Other: _____	☐ No ☐ Yes		____weeks/____months

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URC MALE INFERTILITY HISTORY

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Male Infertility Questionnaire

Family History

How many brothers do you have? _____ How many sisters? _____

Have any blood relatives had any difficulty conceiving children? ☐ No ☐ Yes
If yes, who? (i.e. brother, sister, cousin) _____

Have you or any blood relatives been diagnosed with any of the following conditions?	**Check one:**	**Self or relative (i.e. brother/sister/cousin)**	**When was it diagnosed? (month/year)**
Klinefelter's	☐ No ☐ Yes	_____	_____/_____
Kallman's	☐ No ☐ Yes	_____	_____/_____
Y-chromosome microdeletions	☐ No ☐ Yes	_____	_____/_____
Cystic Fibrosis	☐ No ☐ Yes	_____	_____/_____
Kidney problems	☐ No ☐ Yes	_____	_____/_____
Congenital Deformities	☐ No ☐ Yes	_____	_____/_____
Mental Retardation	☐ No ☐ Yes	_____	_____/_____
Other inherited disorder:	☐ No ☐ Yes	_____	_____/_____

Partner's History

Has your current partner been diagnosed with an obstruction of her fallopian tubes? ☐ No ☐ Yes ☐ Don't Know

Has your current partner ever had a pelvic infection? ☐ No ☐ Yes ☐ Don't Know

Does your current partner have (or ever had) endometriosis? ☐ No ☐ Yes ☐ Don't Know

Had your current partner needed medication to stimulate her ovaries? ☐ No ☐ Yes ☐ Don't Know

Are your current partner's menstrual cycles regular or irregular? ☐ Regular ☐ Irregular ☐ Don't Know

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