

URC Male Infertility Questionnaire

Name: _____
Partner's Name: _____

Date of Birth: _____
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? ____

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

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

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

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?

- Clomid
- Hormone injections
- Other

No Yes – what kinds?

- No Yes For how long? _____
- No Yes For how long? _____
- No Yes For how long? _____

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 University of Washington Physicians
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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	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
	Measles	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
	Mumps	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
	Other	<input type="checkbox"/> No <input type="checkbox"/> 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)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other antidepressant, names: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other psychiatric drugs, names: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Beta-blockers (i.e. Tenormin, Lopressor, Trandate)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Calcium-channel blockers (i.e. nifedipine, verapamil, cardizem)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other antihypertensive drugs (blood pressure medicine), names: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Steroids (i.e. prednisone, medrol)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other immunosuppressant drugs, names: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Insulin	<input type="checkbox"/> No <input type="checkbox"/> Yes
Tagamet (cimetidine)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Zantec (ranitidine)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Zovirax (acyclovir)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Propecia, for how long? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Minoxidil, for how long? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Finasteride, for how long? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes

Have you ever been diagnosed with any of the following?

Type	Check One	If yes, since when?
Thyroid disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____
Sickle cell disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____
Color blindness	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____
Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____
Heart problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____
describe: _____		
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____
High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____

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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		Yes	No		Yes	No
<u>General:</u>			<u>Intestinal:</u>			<u>Neurologic/psychiatric:</u>		
Weight change without trying	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Weakness in limbs	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or passing out	<input type="checkbox"/>	<input type="checkbox"/>
Lost of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal bloating	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Awakening due to pain	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety or panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
						Depression or blue moods	<input type="checkbox"/>	<input type="checkbox"/>
<u>Head/eyes/ears/throat:</u>			<u>Glands/lumps:</u>			<u>Endocrine:</u>		
Changes in your eyesight	<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	Thirsty all the time	<input type="checkbox"/>	<input type="checkbox"/>
Hoarse voice	<input type="checkbox"/>	<input type="checkbox"/>	Lump or mass elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	Can't stand heat or cold	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____					
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	(describe/location)					
Bleeding from gums	<input type="checkbox"/>	<input type="checkbox"/>						
<u>Heart:</u>			<u>Skin:</u>			Do you have any other health		
Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	Non-healing sore(s)	<input type="checkbox"/>	<input type="checkbox"/>	concerns that your provider		
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Changing mole(s)	<input type="checkbox"/>	<input type="checkbox"/>	should know about today? <input type="checkbox"/> <input type="checkbox"/>		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>				If yes, please explain:		
<u>Lungs:</u>			<u>Joints, bones, and muscles:</u>					
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Muscle or bone pain	<input type="checkbox"/>	<input type="checkbox"/>			
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Painful joints	<input type="checkbox"/>	<input type="checkbox"/>			
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>						

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Male History

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Chlamydia – date: ___/___/___ | <input type="checkbox"/> Gonorrhea – date: ___/___/___ | <input type="checkbox"/> Herpes – date: ___/___/___ |
| <input type="checkbox"/> Genital warts/HPV – date: ___/___/___ | <input type="checkbox"/> Syphilis – date: ___/___/___ | <input type="checkbox"/> HIV/AIDS – date: ___/___/___ |
| <input type="checkbox"/> Hepatitis – date: ___/___/___ | <input type="checkbox"/> Other – date: ___/___/___ | |

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Prostate (or prostatitis) – date: ___/___/___ | <input type="checkbox"/> Epididymis – date: ___/___/___ | <input type="checkbox"/> Testes – date: ___/___/___ |
| <input type="checkbox"/> Urethra – date: ___/___/___ | <input type="checkbox"/> Urinary tract or bladder – date: ___/___/___ | |

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

- | | |
|---|---|
| <input type="checkbox"/> Blood in your semen – date: ___/___/___ | <input type="checkbox"/> Pain after ejaculation – date: ___/___/___ |
| <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Right Left Both	___/___/___
Have your testes been surgically brought down to your scrotum?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Right Left Both	___/___/___
Have you had a testicle removed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Right Left Both	___/___/___
Have you ever had a hernia repair?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Right Left Both	___/___/___
When you were younger did your testes ever twist?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Right Left Both	___/___/___
Was surgery ever done to untwist your testes?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Right Left Both	___/___/___
Have you ever been diagnosed with hypospadias (urethral opening is along the penile shaft rather than at the tip)?	<input type="checkbox"/> No <input type="checkbox"/> Yes		___/___/___
Have you ever had a vasectomy?	<input type="checkbox"/> No <input type="checkbox"/> Yes		___/___/___
Have you ever had a vasectomy reversal?	<input type="checkbox"/> No <input type="checkbox"/> Yes		___/___/___
Have you ever had a hydrocele repair?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Right Left Both	___/___/___
Have you ever had a varicocele repair?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Right Left Both	___/___/___
Have you had any other surgery on your scrotum or testicle? Please describe:	<input type="checkbox"/> No <input type="checkbox"/> 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 Questionnaire

In the past 6 months,

- | | | | | | |
|--|--|---|---|--|---|
| How do you rate your confidence that you could get and keep an erection? | <input type="checkbox"/> Very Low | <input type="checkbox"/> Low | <input type="checkbox"/> Moderate | <input type="checkbox"/> High | <input type="checkbox"/> Very High |
| When you had erections with sexual stimulation, how often were your erections hard enough for penetration? | <input type="checkbox"/> Almost never/Never | <input type="checkbox"/> A few times (less than half) | <input type="checkbox"/> Sometimes (about half) | <input type="checkbox"/> Most of time (more than half) | <input type="checkbox"/> Almost always/Always |
| During sexual intercourse, how often do you maintain your erection to completion of intercourse? | <input type="checkbox"/> Almost never/Never | <input type="checkbox"/> A few times (less than half) | <input type="checkbox"/> Sometimes (about half) | <input type="checkbox"/> Most of time (more than half) | <input type="checkbox"/> Almost always/Always |
| During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse? | <input type="checkbox"/> Extremely difficult | <input type="checkbox"/> Very difficult | <input type="checkbox"/> Difficult | <input type="checkbox"/> Slightly difficult | <input type="checkbox"/> Not difficult |
| When you attempted sexual intercourse, how often was it satisfactory for you? | <input type="checkbox"/> Almost never/Never | <input type="checkbox"/> A few times (less than half) | <input type="checkbox"/> Sometimes (about half) | <input type="checkbox"/> Most of time (more than half) | <input type="checkbox"/> Almost always/Always |

Please check one:

Currently,

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

Please check one:

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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? _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____ per week	_____
Did you drink coffee or caffeinated beverages?	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____ per week	_____
Did you drink alcoholic beverages?	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____ per week	_____
Have you ever used any other drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____ per week	_____

Have you ever taken any of the following male enhancers? Check one:

	Check one:	When?	For how long?
Maxoderm	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____ weeks/_____ months
Enzyte	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____ weeks/_____ months
Stamina Rx	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____ weeks/_____ months
Libido-Max	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____ weeks/_____ months
Vazozyne	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____ weeks/_____ months
Ogo-plex	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____ weeks/_____ months
Extagen	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____ weeks/_____ months
Black Pearl	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____ weeks/_____ months
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Testosterone If yes, please circle all that were used: <i>Injectable forms:</i> Testosterone (Malogen, Malogex, Delatestryl, Testoject) Testosterone cypionate (Depo-testosterone, Textex) Testosterone enanthate (Delatestryl) Nandrolone (Deca-Durabolin, Durabolin, Kabolin, Nandrobolic) <i>Oral forms:</i> Oxandrololone (Anavar) Oxymetholone (Andadrol, Anapolon 50, Androyd) Fluoxymesterone (Halostestin, Ora-Testryl, Ultradren) Methyltestosterone (Android, Estratest, Testred, Virilon)	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Dihydrotestosterone (Stanolone)	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Methandrostenolone (Dianabol)	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Other Testosterones If yes, please circle all that were used: Bolasterone (Vebonol) Clostebol (Steranabol) Dehydrochloromethyl-testosterone (Turinabol) Dihydrotestosterone (Stanalone) Mesterolone (Androviron, Proviron) Metandienone/Methandrostenolone (Danabol, Dianabol, Dianabol) Methenolone (Primobolan, Promonabol-Depot) Norethandrolone (Nilevar)	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Mass System Nitro T3	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Tribex	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Vitrix	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Universal Animal Stak2	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Secretagogue-One	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes		___ weeks/ ___ months

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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	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	____/____
Kallman's	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	____/____
Y-chromosome microdeletions	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	____/____
Cystic Fibrosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	____/____
Kidney problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	____/____
Congenital Deformities	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	____/____
Mental Retardation	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	____/____
Other inherited disorder:	<input type="checkbox"/> No <input type="checkbox"/> 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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