

*DATE _____

JHH # _____

FERTILITY QUESTIONNAIRE

PATIENT: Please complete only those portions marked with an *

*NAME _____
Last First Middle

*BIRTHDATE _____ *OCCUPATION _____

*REFERRING PHYSICIAN: _____

*SPECIALTY (UROLOGIST, GYNECOLOGIST, ETC.): _____

*PRIMARY CARE PHYSICIAN: _____

*WIFE'S NAME _____
LAST FIRST MAIDEN

*WIFE'S BIRTHDATE: _____ *GYNECOLOGIST: _____

PATIENT HISTORY

MARITAL HISTORY:

*HUSBAND AGE: _____ *WIFE 'S AGE: _____

*YEARS TRYING TO CONCEIVE: _____

*BIRTH CONTROL USED IN THE PAST: _____

*PREVIOUSLY MARRIED (Y,N): HUSBAND: _____ WIFE: _____

*PREVIOUS PREGNANCIES (#): HUSBAND: _____ WIFE: _____

***PREVIOUS EVALUATION:** YES NO (CIRCLE ONE)

SEMEN ANALYSIS: _____

ENDOCRINE TESTING: _____

TESTIS BIOPSY: _____

PREVIOUS FERTILITY THERAPIES:

MEDICATION: _____

INTRAUTERINE INSEMINATIONS: _____

IN VITRO FERTILIZATION: _____

SURGERY : _____

SEXUAL HISTORY:

*POTENCY (Normal or Abnormal)_____

*ARE YOU USING LUBRICANTS WITH INTERCOURSE (Y,N): _____

*DO YOU EXPERIENCE PAIN WITH EJACULATION (Y,N): ____

SPOUSE (WIFE) EVALUATION:

*IS YOUR WIFE'S EVALUATION (NORMAL, ABNORMAL, INCOMPLETE): _____

*HAS YOUR WIFE RECEIVED HORMONAL STIMULATION? (Y,N): _____

*DOES YOUR WIFE HAVE REGULAR MENSTRUAL CYCLES? (Y,N): _____

TESTING OF SPOUSE

BBT_____ PC TEST_____

ENDOMETRIAL BX_____ LAPAROSCOPY_____

HSG_____ LAPAROTOMY_____

GU DISEASES:

TESTICULAR DESCENT (Normal, Bilateral Crypt., Unilateral Crypt.) _____

SEXUAL DEVELOPMENT (N,A) _____

VENEREAL DISEASE (Y,N) _____

MUMPS ORCHITIS (Y,N) _____

CHEMICAL EXPOSURE (Y,N) _____

EPIDIDYMITIS (Y,N) _____

RADIATION EXPOSURE (Y,N) _____

EXPOSURE TO HEAT (Y,N) _____

TRAUMA (Y,N) _____

HISTORY OF TORSION (Y,N) _____

RECENT FEVER (Y,N) _____

MEDICAL HISTORY:

*MEDICAL ILLNESSES: _____

*MEDICATIONS: _____

*ALLERGIES: _____

*PREVIOUS SURGERIES: _____

*DO YOU SMOKE (Y/N): _____ *IF SO, HOW MUCH (Pkgs per day) : _____

*DID YOU USED TO SMOKE (Y/N): _____ *IF SO, YEARS QUIT: _____

*WHAT IS YOUR CURRENT ALCOHOL CONSUMPTION (Drinks per day): _____

*HAVE YOU EVER HAD PROBLEMS WITH ALCOHOL (Y/N): _____

*DO YOU USE RECREATIONAL DRUGS (Y/N): _____

FAMILY HISTORY OF (Y,N):

DIABETES _____ HYPERTENSION _____

CANCER _____ HEART DISEASE _____

*DO YOU HAVE A FAMILY HISTORY OF INFERTILITY (Y/N): _____

PHYSICAL EXAMINATION

*WEIGHT (LBS) _____ *HEIGHT (IN) _____ RACE: _____

TEMP.: _____ PULSE: _____ RESP.: _____

PHALLUS _____ LUNGS _____

CIRCUMCISED (Y,N) _____ HEART _____

MEATUS (N,A) _____ ABDOMEN _____

SECONDARY SEX CHARACTERISTICS:

NORMAL _____ ABNORMAL _____

TESTES EXAM:

RIGHT

LEFT

LOCATION (S,I,A) _____

LOCATION (S,I,A) _____

SIZE _____

SIZE _____

SPERMATOCELE (Y,N): _____

SPERMATOCELE (Y,N): _____

HYDROCELE (Y,N) _____

HYDROCELE (Y,N) _____

VARICOCELE (S,M,L,N) _____

VARICOCELE (S,M,L,N) _____

VAS DEFERENS (N,Abnl,Abs) _____

VAS DEFERENS (N,Abnl,Abs) _____

EPIDIDYMIS (N,A) _____

EPIDIDYMIS (N,A) _____

PROSTATE (N,A) _____

MASSES (Y,N) _____

LABORATORY TESTS:

SEMEN ANALYSIS: _____

SCROTAL ULTRASOUND: _____

POSTEJACULATORY U/A: _____

TESTIS BIOPSY: _____

ANTISPERM ANTIBODIES: _____

MESA: _____

FREE TESTOSTERONE: _____

TESE: _____

FSH: _____

SVA: _____

PROLACTIN: _____

SVG: _____

LH: _____

KARYOTYPE: _____

ESTRADIOL: _____

GENETICS COUNSELING: _____

TRUS: _____

DIAGNOSIS #1: _____

DIAGNOSIS #2: _____