



Marc Goldstein, MD, DSc (hon), FACS
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Surgeon-in-Chief, Male Reproductive Medicine and Surgery

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www.maleinfertility.org

Dear Patient,

Your appointment with Marc Goldstein, M.D., is on _____, 20____ at _____.
Our office is located at New York – Weill Cornell Medical Center, **520 East 70th Street and York Ave ninth floor** of the Starr Pavilion (Room-Starr 900), Department of Urology. You are encouraged to bring your wife or partner with you although her presence is not mandatory.

Please be sure to complete the enclosed 4 page forms and the referring physician form, before arriving for your appointment. You must obtain a copy of all your test results including semen analyses, blood hormone levels, operative report (if applicable), glass testicular biopsy slides (if applicable). Keep one copy for your records and bring one copy at the time of your appointment. **PLEASE DO NOT MAIL ANY OF THE FORMS OR RESULTS TO THE OFFICE.**

The initial consultation fee varies from \$450 - \$510, depending on the length and complexity of your visit with the doctor. It includes an initial interview, and complete physical examination followed by a discussion of your treatment plan. Payment is expected at the time of the visit. Dr. Goldstein is not a participating provider with any insurance company. We issue a physician’s statement, which can be attached to your own insurance form for reimbursement.

*** PLEASE NOTE:** Patients will be billed for those appointments not cancelled within 48 hours. We have a 24-hour answering service available. **◆ YOU MUST CALL TO CONFIRM AT LEAST 2 DAYS BEFORE YOUR SCHEDULED APPOINTMENT. IF YOU DO NOT CONFIRM, YOUR APPOINTMENT WILL BE AUTOMATICALLY CANCELLED.◆**

Thank you for your cooperation.

Center for Male Reproductive Medicine

Center for Male Reproductive Medicine and Microsurgery

History and Examination Questionnaire

	Yes	No															
<p>Please fill out the following form as honestly and completely as you can. The purpose of this information is to help assess your reproductive potential. All information will be held in strict confidence. (Please bring this form with you on your first visit.)</p>																	
Identification:																	
1. Name: _____																	
2. Address: _____ _____																	
3. Birthdate: _____ 4. Age: _____																	
5. Date of Appointment: _____ / _____ / _____																	
6. RUH # _____																	
7. NYH # _____																	
8. Telephone (home) _____																	
9. (business) _____																	
10. Referred by: _____																	
11. Relative or Friend : _____																	
12. Marital status (partner's name) _____																	
13. Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>																	
A. Fertility History																	
1. For how many months have you been trying to achieve pregnancy with your current partner? _____																	
2. How old is she? _____																	
3. Have you achieved pregnancy with your current partner in the past? Yes <input type="checkbox"/> No <input type="checkbox"/>																	
4. If yes, give date and outcome of pregnancies (i.e. spontaneous abortion, induced abortion, caesarean section, still birth, ectopic pregnancy, birth defects, premature birth, normal delivery). <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Outcome & Length of Pregnancy</th> <th style="width: 20%; text-align: center;">Date of outcome</th> </tr> </thead> <tbody> <tr> <td>Pregnancy #1 _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Pregnancy #2 _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Pregnancy #3 _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Pregnancy #4 _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Outcome & Length of Pregnancy	Date of outcome	Pregnancy #1 _____	_____	_____	Pregnancy #2 _____	_____	_____	Pregnancy #3 _____	_____	_____	Pregnancy #4 _____	_____	_____		
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Pregnancy #1 _____	_____	_____															
Pregnancy #2 _____	_____	_____															
Pregnancy #3 _____	_____	_____															
Pregnancy #4 _____	_____	_____															
5.7 Have you ever undergone sterilization? _____																	
5.8 Has your partner ever undergone sterilization? _____																	
5.9 Have you been examined for infertility problems elsewhere? _____																	
5.10 Have you received treatment for infertility problems elsewhere? _____																	
5.11 Has your partner been examined for fertility problems? _____																	
5.12 Have you made any previous partner pregnant? _____																	
5.13 If yes, give date and outcome of pregnancies (i.e. spontaneous abortion, induced abortion, caesarean section, still birth, ectopic pregnancy, birth defects, premature birth, normal delivery) <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Outcome & Length of Pregnancy</th> <th style="width: 20%; text-align: center;">Date of outcome</th> </tr> </thead> <tbody> <tr> <td>Pregnancy #1 _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Pregnancy #2 _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Pregnancy #3 _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Pregnancy #4 _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Outcome & Length of Pregnancy	Date of outcome	Pregnancy #1 _____	_____	_____	Pregnancy #2 _____	_____	_____	Pregnancy #3 _____	_____	_____	Pregnancy #4 _____	_____	_____		
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Pregnancy #2 _____	_____	_____															
Pregnancy #3 _____	_____	_____															
Pregnancy #4 _____	_____	_____															
5.14 Has your current partner had any pregnancies previously with someone other than you? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
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C. Sexual History																	
1. Rate your level of sexual desire																	
1.1 Marked _____																	
1.2 Moderate _____																	
1.3 Slight _____																	
1.4 None _____																	
2. How many times each week do you have sexual intercourse? _____																	
3. Do you experience ejaculation (come) during sexual intercourse? _____	Yes	No															
4. Do you ejaculate (come) into your partner's vagina? _____																	
5. Does semen leak out of your partner's vagina after intercourse? _____																	
6. How often do you ejaculate (come)? _____ times per week.																	
7. How often do you masturbate? _____ times per week.																	
8. Do you obtain an erection easily? _____	Yes	No															
9. Do you often have erections in the morning? _____																	
10. Are you aware of erections in the night? _____																	
11. Do you maintain your erection sufficiently for intercourse? _____																	
12. Have you ever ejaculated through a flaccid (soft) penis? _____																	
13. Do you ever ejaculate (come) prior to penetration for intercourse? _____																	

Yes No

- 14. About how long does intercourse last before you ejaculate (come)?
_____ minutes.
- 15. Is intercourse ever painful to you? _____
- 16. Is intercourse painful for your partner? _____
- 17. Is her vagina ever so tight that you cannot penetrate? _____
- 18. Does she usually reach orgasm? _____
- 19. If yes, through intercourse? _____
- 20. Through other sexual activity? _____
- 21. Does her response in any way affect your sexual performance? _____
- 22. Do you use any form of lubrication for intercourse? _____
- 23. Do you ever ejaculate into your partner's rectum? _____
- 24. Does your partner ever swallow your semen? _____
- 25. Is your partner subject to vaginal infections? _____
- 26. Does your partner douche immediately following intercourse? _____

- 27. Rate your partner's sexual desire
- 27.1 Marked _____ 27.3 Slight _____
- 27.2 Moderate _____ 27.4 None _____

- 28. Are your partner's menstrual periods regular? _____
- 29. Has your partner had any of the following illnesses
- 29.1 Herpes _____
- 29.2 Pelvic inflammatory disease _____
- 29.3 Venereal disease _____
- 29.4 Gonorrhoea _____
- 29.5 Non-specific urethritis _____
- 29.6 Syphilis _____
- 30. Has your partner had abdominal surgery? _____
- 31. Do you have intercourse every other day during the ovulation cycle? _____

- 32. Does your partner usually get out of bed immediately following intercourse? _____
- 33. Do you have a satisfactory marital adjustment? _____

D. General Medical History

Yes No Age at Diagnosis

- 1. Have you ever had any of the following illness or conditions?
- 1.1 Allergies _____
If yes, please specify _____
- 1.2 Arthritis _____
- 1.3 Bowel Disorder _____
- 1.4 Cancer _____
- 1.5 Change in Body Appearance _____
- 1.6 Change in Facial Appearance _____
- 1.7 Color Blindness _____
- 1.8 Deafness _____
- 1.9 Diabetes _____
- 1.10 Heart Problems(including mitral valve prolapse) _____
- 1.11 Hepatitis _____
- 1.12 Liver Disease _____
- 1.13 Lung or breathing problems _____
- 1.14 Thyroid Disease _____
- 1.15. Generalized viral infections _____
(i.e. mono, encephalitis)

Yes No Age at Diagnosis

- 1.16 Nervous system disease _____
- 1.17 Sickle cell disease _____
- 1.18 Smallpox _____
- 1.19 Influenza _____
- 1.20 Tuberculosis _____
- 1.21 Ulcers _____
- 1.22 Frequent episodes of indigestion or abdominal pain _____
- 1.23 Neck or back problems _____
If yes, please specify _____
- 1.24 Skin diseases _____
- 1.25 High blood pressure _____

E. Urologic history

Have you ever had:

- 1. infection of the prostate? _____
- 2. infection of the epididymis? _____
- 3. infection of your testicles? _____
- 4. kidney or bladder stones? _____
- 5. a venereal infection? _____
- 6. Non-specific Urethritis? _____
- 7. Gonorrhoea? _____
- 8. Syphilis? _____
- 9. Herpes? _____
- 10. Have you ever had a white, green or yellow discharge from the end of your penis? _____
- 11. Have you ever had a urinary tract infection? _____
- 12. Have you had a fever in the past three months? _____
- 13. Have you ever had blood in your semen? _____
- 14. Have you ever had pain in your scrotum or testicles? _____
- 15. Were both of your testicles descended at birth? _____
- 16. Have you ever had any injury to your testicles or penis? _____
- 17. Have you ever had mumps? _____
- 18. Is yes, did it affect your testicles? _____

Have you ever had an operation for:

Yes No Year

- 19.1 Hernia? _____
- 19.2 Varicocele (varicose veins in scrotum)? _____
- 19.3 Hydrocele? _____
- 19.4 Undescended testis? _____
- 19.5 Any abdominal surgery? _____
If yes, please specify _____
- 19.6 Operation on testicles? _____
- 19.7 Vasectomy? _____
- 19.8 Circumcision or other surgery on penis? _____
- 19.9 Other surgery? _____
If yes, please specify _____

F. Endocrine History

Yes No

- 1. Do you have, or have you ever had:
- 1.1 Difficulty smelling? _____

- 9
- 1.2 Headaches? _____ Yes No
- 1.3 Visual problems? _____
- 1.4 Enlarging hands and feet? _____
- 1.5 Problems with perspiration/sweating? _____
- 1.6 Changing skin color? _____
- 1.7 Frequent episodes of lightheadedness or dizziness? _____
- 1.8 Growth problems? _____
- 1.9 Do you have a general sense of well-being? _____
- 1.10 Do you notice a recent change in your energy level? _____
- 1.11 Do you have wide mood swings? _____
- 1.12 At what age did you first note armpit hair? _____
- 1.13 At what age did you first note public hair? _____
- 1.14 At what age did you start to shave? _____
- 1.15 How often do you need to shave?
 1. Twice a day 2. Every two days 3. Once a day
 4. Twice a week or less 5. Any change _____
- 1.16 How does your beard compare with men of your family?
 1. Same 2. Sparser 3. Heavier

G. Occupational History

1. What is your present occupation? _____
2. Past occupations: _____

- Yes No
3. Is your occupation stressful? _____
4. Do you need to meet rigid deadlines or time schedules? _____
5. How many hours do you work per week? _____
6. Do you frequently travel? _____
7. Do you fall asleep easily? _____
8. Do you wake up early? _____

9. In your work or elsewhere, have you been exposed to any of the following:

Name (if possible)

- 9.1 Prolonged heat _____
- 9.2 Radiation _____
- 9.3 Pesticides _____
- 9.4 Agent Orange _____
- 9.5 Industrial Solvents _____
- 9.6 Dyes _____
- 9.7 Heavy metals _____
- 9.8 Plastics _____

H. Medication and Drugs

Are you taking or have you ever taken any of the following medications?

- Currently Previously Never
1. Allopurinol _____
2. Antidepressant drugs _____
3. Antihistamines _____
4. Antihypertensive drugs _____
5. Antiparasite agents _____
6. Anti psychotic agents _____
7. Aspirin _____
8. Barbiturates _____
9. Chemotherapy for cancer _____
10. Cholestyramine _____
11. Clofibrate _____

- Currently Previously Never
12. Digitalis _____
13. Dilantin _____
14. Diuretics _____
15. Hormones _____
16. Immunosuppressant drugs _____
17. Insulin _____
18. Nicotinic Acid _____
19. Norpace _____
20. Penicillin _____
21. Streptomycin _____
22. Sulfa drugs _____
23. Tagamet (Cimetadine) _____
24. Tetracycline _____
25. Tranquilizers _____
26. Propecia or Proscar _____
27. Alternative Medicines _____
28. Other: _____

I. Social History

- Yes No For how many years?
1. Do you smoke? _____
2. How many cigarettes do you have each day? _____
3. How many marijuana cigarettes do you have each day? _____
4. How many alcoholic drinks do you have each day? _____
5. How many cups of coffee or caffeine-containing sodas do you drink each day? _____

6. Do you use any of the following substances?

- Yes No
- 6.1 Cocaine _____
- 6.2 LSD _____
- 6.3 Amphetamines _____
- 6.4 Quaalude _____
- 6.5 Angel Dust _____
- 6.6 Heroin _____
- 6.7 Methadone _____

7. Do you take long baths, saunas, Jacuzzis or steam on a regular basis? _____

J. Family History

1. Was your mother ever given diethylstilbestrol (DES)? _____
2. How many sisters do you have? _____
3. Give the number of children of each of your sisters
 1. Sister #1 _____ 3. Sister #3 _____
 2. Sister #2 _____ 4. Sister #4 _____
4. How many brothers do you have? _____
5. Give the number of children of each of your brothers
 1. Brother #1 _____ 3. Brother #3 _____
 2. Brother #2 _____ 4. Brother #4 _____
6. Are any of the following diseases or conditions present in your family?
- 6.1 Birth Defects _____
- 6.2 Bowel disorders _____
- 6.3 Cancer _____
- 6.4 Cystic fibrosis _____
- 6.5 Diabetes _____

	Yes	No
6.6 Extra fingers or toes	_____	_____
6.7 Heart disease	_____	_____
6.8 High blood pressure	_____	_____
6.9 Hormone problems	_____	_____
6.10 Kidney disease	_____	_____
6.11 Lung disease	_____	_____
6.12 Poor sense of smell	_____	_____
6.13 Tuberculosis	_____	_____
6.14 Ulcers	_____	_____

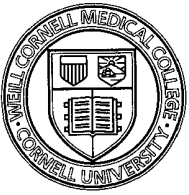
FOR PHYSICIAN'S USE

1. Date _____
2. Temp _____
3. Height _____
4. Weight in lbs _____
5. BP _____
6. Pulse _____
7. Resp. _____
8. Span in cm _____
9. Symphysis to floor in cm _____
10. Symphysis to crown in cm _____
11. General Appearance (NL) _____ Abnormal
12. Skin _____
13. Fundoscopy _____
14. Eyes close together _____
15. Head & Neck _____
16. Facies _____
17. Palate _____
18. Back & Spine _____
19. Thyroid _____
20. Heart _____
21. Lungs _____
22. Abdomen _____
23. Extremities _____
24. Short 4th metacarpal _____
25. Short 4th metatarsal _____
26. Do knees touch when ankles are together? _____
27. Neurological exam _____
28. Hair dist. _____
- 28.1temporal _____ 28.2facial _____ 28.3 pubic _____ 28.4auxillary _____ 28.5 chest _____
29. Fat dist. _____
30. *Gynecomastia* _____
31. Nipples widely spaced _____
32. Musculoskeletal _____
33. Escutcheon _____
34. Penis _____ 34.1 Length _____ 34.2 Foreskin _____
35. Scrotum _____ R _____ L _____
36. Testis volume _____
37. Testis consistency _____
38. Epididymis _____
39. Vas deferens _____
40. Varicocele _____
41. Prostate _____
- 41.1 symmetry _____
- 41.2 consistency _____

- 41.2 tenderness _____
- 41.3 nodules _____
- 41.4 mass _____
42. Seminal vesicles _____
43. Other _____
44. Diagnosis _____
45. Plan _____
46. Inclusion in protocol # _____

47. History of Present Illness

Marc Goldstein, M.D.



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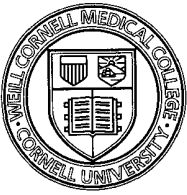
PLEASE FILL IN THE NAME AND ADDRESS OF THE DOCTOR OR RABBI
WHO REFERRED YOU TO DR. GOLDSTEIN.

NAME

MEDICAL SPECIALTY

ADDRESS

TELEPHONE NUMBER



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PATIENT ALERT

DEAR PATIENT:

THE LABORATORY TESTS ESSENTIAL FOR A THOROUGH INFERTILITY EVALUATION ARE OFTEN QUITE COSTLY. YOU ARE RESPONSIBLE FOR KNOWING THE POLICIES AND PROCEDURES OF YOUR INSURANCE CARRIER REGARDING ALLOWABLE LABORATORIES AND COVERAGE FOR ALL SERVICES.

FAILURE TO USE THESE LABORATORIES WILL RESULT IN DENIAL OF COVERAGE FOR THESE SERVICES. PLEASE INFORM THE OFFICE PERSONNEL THAT YOU MUST USE THESE LABORATORIES AND YOU WILL BE GIVEN A PRESCRIPTION (AUTHORIZATION) TO BRING TO THE APPROPRIATE LABORATORY.

YOU MAY CALL THE TELEPHONE NUMBERS LISTED BELOW FOR A LABORATORY THAT IS CONVENIENT FOR YOU:

LABCORP (NEW YORK 1-800-788-9091) (NJ 1-800-631-5250 X2642)

QUEST 1-800-225-7483 OR 1-800-222-0446