Male Fertility Evaluation Questionnaire

Please complete this questionnaire as completely & honestly as possible. Please bring this form with you to your initial consultation with Dr. Schlegel. If any semen analyses, blood tests, or other evaluations have been previously performed, please bring these reports and/or have any other doctors fax the reports to us at (212) 746-8425. If a testis biopsy has been performed, please bring the glass slides of the biopsy (obtained from The Department of Pathology where the biopsy was done.)

Background Information:

Name:_____
Address:_____
_____
Birthdate:_____ Age:_____
Telephone: (Work) (____) ____-
Telephone: (Home) (____) ____-
Partner's Name: _____
Marital Status:_____
Who Referred You?:_____
Relationship to you:_____

Fertility History

How many months have you been trying to achieve pregnancy with your current partner?: _____
Have you ever achieved a pregnancy with your partner in the past?: _____
If yes, please give date & outcome of pregnancies:

How many months have you lived with your partner: ___
Did you use birth control before attempting to conceive?: _____
What methods did you use?:

Have you ever contributed to a pregnancy with another partner?: _____
Please present the outcome of these pregnancies:

Has your current partner ever had any pregnancies with another man?: _____
Please describe the outcome of these pregnancies:

How old is your partner?: _____
Has she had any tests for evaluation of her fertility?:

Does she ovulate every month? _____

Past Medical History:

	Yes	No	Age at Diagnosis
Allergy to medications	__	__	
Arthritis	__	__	
Bowel Disorders	__	__	
Cancer	__	__	
Change in Body Appearance	__	__	
Color Blindness	__	__	
Deafness	__	__	
Diabetes	__	__	
Disk Problems	__	__	
Heart Problems	__	__	
Hepatitis	__	__	
High Blood Pressure	__	__	
Indigestion or frequent abdominal pain	__	__	
Other Liver Problems	__	__	
Lung or Breathing Problems	__	__	
Thyroid Disease	__	__	
Nervous System Diseases	__	__	
Sickle Cell Disease	__	__	
Sinus Problems	__	__	
Skin diseases	__	__	
Spinal cord problems	__	__	
Tuberculosis	__	__	
Ulcers	__	__	

Any medications taken on a regular basis (& dose):

Have you been given any antibiotics in the past 3 months?:

Have you ever taken any of the following medications:

Allopurinol	__
Antidepressant drugs	__
Antihypertensive drugs	__
Antiparasitic Agents	__
Antipsychotic medications	__
Barbiturates	__
Chemotherapy for cancer	__
Cholesterol-lowering drugs	__
Clomid	__
Dilantin	__
hCG injections	__
Hormones	__
Immunosuppressant drugs	__
Insulin	__
Tagamet (cimetidine)	__
Tranquilizers	__
Zantac (ranitidine)	__
Zovirax (acyclovir)	__

Urological History

Have you ever had an infection involving:

Prostate (or prostatitis)	__	__
Epididymis (epididymitis)	__	__
Testes	__	__
Venereal(sexually transmitted)infection		__
Urethritis (or NSU)	__	__
Gonorrhea	__	__
Herpes	__	__
Syphilis	__	__
Urinary tract(urinary/bladder)infection	__	

Have you ever:

Had blood in your semen?	__	__
Had pain after ejaculation?	__	__
Had prolonged pain or swelling of testes?		

	Yes	No	Date
Have you:			
Developed mumps after puberty?	__	__	
Did it cause pain in your testes?	__	__	
Had a fever (>101^{o}F) for more than 1 day in the past 3 months?	__	__	

Surgical history:

Have you had any operations on the urinary tract, including the bladder or prostate?	__	__	
Have you ever had a vasectomy?	__	__	
Vasectomy reversal?	__	__	
Other microsurgery for infertility?	__	__	
Any of the following procedures:			
Hernia	__	__	
Varicocelectomy (for enlarged veins in the scrotum)	__	__	
Hydrocele repair	__	__	
Testis biopsy	__	__	
Other operations on the testis	__	__	
Operations on the penis	__	__	
Other Operations (describe):			
Been told that your testes did not descend? had to surgically be moved?	__	__	

Hormonal Development & Changes:

Have you been able to smell?	__		
Do you have frequent headaches?			
Has your vision changed recently?			
Have you had a recent change in your energy level?	__	__	
Did your armpit and pubic hair develop at the same time as other boys your age?	__		
If not, when did you go through puberty?			
Do you have more or less chest hair than other men in your family?	__		

Social/Drug Exposures

Do you take long hot baths, saunas or jaccuzzis?	__		
Do you smoke?	__		
If so, how many packs/day?			
Have you smoked marijuana heavily in the past?	__	__	
How many drinks do you have in an average week?	____		
Do you ever drink more than 2-3 drinks in a 24 hour period?	__	___	
How many cups of coffee or caffeine-containing drinks do you have/day?			

Do you currently use, or have you extensively used any of the following substances:

Cocaine	__	__	
LSD	__	__	
Amphetamines	__	__	
Heroin	__		

What type of work do you do?

_____

Exposures (other):

Have you ever been heavily exposed to toxins, poisons, pesticides, radiation or solvents?

Sexual History:

Please rate your interest in sex:
(None, minimal, moderate, intense)
How many times a week do you ejaculate?
How often do you masturbate(per week)

	Yes	**No**
Do you ejaculate during intercourse?	__	__
Do you ejaculate into your partner's vagina?	__	__
Have you ever been unable to achieve an erection adequate for intercourse?	__	__
Have you ever ejaculated through a soft (flaccid) penis?	__	__
Do you ever ejaculate prior to vaginal penetration?	__	__
Is intercourse ever painful for your partner?	__	__
Is her vagina ever so tight that you cannot penetrate?	__	__
Do you use any lubricant for intercourse? If so, what lubricant: _____		
Do you frequently ejaculate into your partner's rectum?	__	__
Does your partner usually lie down for at least 30 minutes after intercourse?	__	___
Does your partner douche after intercourse?		
Do you have intercourse daily or every other day when your partner is ovulating?	__	__

Family History:

How many brothers do you have?	___	
Do any have fertility problems?	___	
How many sisters do you have?	___	
Do any have fertility problems?	___	
Was your mother ever given DES (diethylstilbesterol) to prevent miscarriage?	___	___
Are any of these problems present in your family:		
Birth Defects	___	___
Cystic fibrosis	___	___
Diabetes	___	___
Hormone Problems	___	___
Kidney Problems	___	___
Prostate Cancer	___	___
Tuberculosis	___	___

Other:

Please describe any other health problems you may have that Dr. Schlegel should know about:

_____

Reviewed by: Peter N. Schlegel, M.D.

Physical Examination (completed by Doctor)

Name: _____ History # _____

PHYSICAL EXAM: All shaded areas must be filled out

CONSTITUTIONAL (record 3 or more vital signs)

- Height_____ Wt_____ BP_____ T_____ P_____ R_____
- General Appearance (Note all that apply)

  □ Well-developed □ Well-nourished □ Well-groomed □ Masculinized □ Feminized

  □ Obese □ Gynecomastia □ Other

SKIN

- Inspection: □ Normal □ Abnormal

NECK

- **Neck** □ Normal □ Abnormal **Thyroid** □ Normal □ Abnormal

RESPIRATORY

- **Respiratory effort** □ Normal □ Abnormal **Auscultation** □ Normal □ Abnormal

CARDIOVASCULAR

- **Auscultation of Heart** □ Normal □ Abnormal **Peripheral Vascular System**. □ Normal □ Abnormal

GASTROINTESTINAL

- **Abdomen** □ Normal □ Abnormal
- **Liver** □ Normal □ Abnormal
- **Spleen** □ Normal □ Abnormal

LYMPHATIC

Palpation of nodes (choose all that are applicable)

- **Neck** □ Normal □ Abnormal **Groin** □ Normal □ Abnormal **Other** □ Normal □ Abnormal

NEUROLOGICAL/PSYCH

- **Orientation** □ Person □ Place □ Time **Mood Affect** □ Normal □ Other

  _____

MALE/ GENITOURINARY

- Hernia (GI) □ Absent □ Present Diagram of testes/ epididymis / vas deferens
- Stool Guaic (GI) □ Positive □ Negative
- Scrotal skin □ Normal □ Abnormal
- Urethral Meatus □ Normal □ Abnormal
- Penis □ Normal □ Abnormal
- Prostate □ Normal □ Abnormal
- Seminal Vesicles □ Normal □ Abnormal
- Anus/Perineum □ Normal □ Abnormal
- Sphincter tone, hemorrhoids, masses □ Normal □ Abnormal

1-5 elements = 99201 or 99212 6 elements = 99203 0r 99213 12 elements = 99203 or 99214 all elements = 99204/5 or 99215

Assessment/Plan:

Total Encounter Time: _____

Time Spent counseling (face-to-face):

_____

_____

Peter N. Schlegel, M.D.