

THE FERTILITY CENTER OF OREGON
Women's Care
590 Country Club Pkwy, Suite A
Eugene, Oregon 97401
(541) 683-1559

••• MALE QUESTIONNAIRE •••

INSTRUCTIONS: Please read the following carefully. Answer this questionnaire honestly and to the best of your ability. Your answers provide a database upon which your doctors will depend in providing your care. Seemingly unimportant facts may have great value.

We will review this questionnaire with you. If for any reason you have any problem in answering or any objection to answering any specific portion of this questionnaire, talk to us in private and explain the situation. Make a mark on the section to remind you to discuss it with us. This confidential questionnaire, as part of your case history, will be held in the strictest confidence according to the ethics of the medical profession.

Name: _____ Preferred name: _____ Date of Birth: _____ Age: ____ Today's Date: _____

Who is your primary care Physician? _____

Who referred you to our care? _____

Main reason for visit (*in your own words*) _____

SEXUAL, FERTILITY HISTORY

How long have you been with your current partner? _____

How often do you have sexual intercourse? ____ Times per day / week / month (*please circle one*)

Do you have a happy sex life? (*check one*) ____ great ____ good ____ fair ____ poor

Have you ever had any problems with any methods of contraception?

____ No ____ Yes (*please explain*) _____

Have you attempted pregnancy with past partners? ____ No ____ Yes

Any pregnancy? ____ No ____ Yes (*list below*) _____

Did you use contraception? ____ No ____ Yes Years used _____ to _____

Type of contraception: _____

Have you ever had a semen analysis? ____ No ____ Yes

If yes, date _____ Result _____

Have you ever had any treatment for infertility, low sperm count, or related problems?

____ No ____ Yes (*list dates, name of doctor/clinic and any treatments*) _____

Have you ever worked with or been exposed to solvents, chemicals, or radiation in your work or hobbies? (including military) ____ No ____ Yes (*explain*) _____

Have you ever had ... (check if yes, and please tell us when)

- Trouble getting an erection _____
- Trouble maintaining an erection for intercourse _____
- Ejaculation (coming) before insertion _____
- Unable to ejaculate during intercourse _____
- "Wet dreams" more often than one per week _____
- Blood in the seminal fluid (ejaculate) _____
- Painful ejaculation _____
- Any other related problem _____

Have you ever had any penile or testicular trauma or surgery? No Yes

If yes, date _____ Injury sustained or surgery done _____

CHILDHOOD: As a child, did you have any of the following problems? (Check if yes, explain/give dates/age to right)

- Mumps _____
- Epilepsy, fits or fainting spells _____
- Any serious illness requiring doctor's care _____
- _____
- Hernia (rupture) _____
- Undescended testicle(s) at any age _____
- Urinary tract infection _____
- Bed wetting _____
- Emotional problems requiring doctor's care _____

Compared to your friends and classmates, when did you note maturational changes in:

- | | | | |
|------------------------------|--------------------------------|---|-------------------------------|
| Pubic hair | <input type="checkbox"/> Early | <input type="checkbox"/> About the same age | <input type="checkbox"/> Late |
| Axillary (armpit) hair | <input type="checkbox"/> Early | <input type="checkbox"/> About the same age | <input type="checkbox"/> Late |
| Penis and testes enlargement | <input type="checkbox"/> Early | <input type="checkbox"/> About the same age | <input type="checkbox"/> Late |
| Voice change | <input type="checkbox"/> Early | <input type="checkbox"/> About the same age | <input type="checkbox"/> Late |
| Shaving | <input type="checkbox"/> Early | <input type="checkbox"/> About the same age | <input type="checkbox"/> Late |

GENITO-URINARY

Have you ever had (check if yes, and please tell us when)

- Gonorrhea (clap, GC) _____
- Blood in urine _____
- Burning or stinging on urination _____
- Discharge from penis (urethra) _____
- Infection of bladder, kidney, or prostate _____
- Trouble starting to urinate _____
- Swelling of scrotum or testis from any cause _____
- Catheterization of bladder (tube inserted to remove urine) _____
- Sounding of urethra (instrument in urethra or penis) _____
- Do you usually have to get up from sleep to urinate? How many times at night? _____

Have you ever taken any of these medications? (check if yes)

- Viagra, Cialis, or Levitra
- Chemotherapy
- Blood pressure medication
- Psychotherapeutic medication (antidepressant, antipsychotic)
- Hormone therapy
 - testosterone
 - anabolic steroids
 - other hormones

MEDICAL HISTORY

Current medical problems: _____

Have you ever had any serious illnesses, injuries, or hospitalizations other than listed above: _____

Date _____ Problem _____ Treatment _____

Date _____ Problem _____ Treatment _____

SURGERIES

Date: _____ Procedure: _____

MEDICATIONS

Med: _____ Dose: _____ Prescriber: _____

ALLERGIES

Allergy to: _____ Reaction: _____

SOCIAL HISTORY

Occupation _____ Are you satisfied with your work? ___ Yes ___ No

Please check: ___ Single ___ Married ___ Same sex ___ Partnered ___ Widowed ___ Divorced

Partner's name: _____ Years with current partner _____

Are you satisfied with your partner? _____

Do you smoke tobacco? ___ No ___ Yes (*if yes, please answer the following*)

If yes, how many packs per day _____ For how many years? _____

Previous tobacco use: Start date _____ Quit date _____ Packs per day _____

Do you use any other tobacco products? ___ No ___ Yes

Do you drink alcohol? ___ No ___ Yes (*if yes, please answer the following*)

___ oz. liquor per (*circle one*) day / week / month

___ 12 oz. glasses beer per day / week / month

___ 6 oz. glasses wine per day / week / month

Have you ever used any non-prescription drugs such as: *(if yes, please indicate when last used)*

- ___ Marijuana _____
- ___ LSD, STP, etc. _____
- ___ Heroin, etc. _____
- ___ Morphine, Demerol, etc. _____
- ___ Barbiturates _____
- ___ Injected drug of any kind _____

Have you ever been treated or diagnosed for anorexia or bulimia? ___ No ___ Yes

If yes, when _____

Have you ever been the victim of sexual, physical, or emotional abuse? _____

Are you currently under stress? _____

FAMILY HISTORY

Please list any members of your family including parents, grandparents, brothers and sisters who have had significant medical problems (such as diabetes, high blood pressure, heart attack, cancer):

Relationship	Medical Problem
Maternal grandmother.....	_____
Maternal grandfather	_____
Paternal grandmother	_____
Paternal grandfather	_____
Mother	_____
Father	_____
Siblings: Brother / Sister <i>(please circle)</i>	_____
Brother / Sister	_____
Brother / Sister	_____
Children	_____

Has anyone in your immediate family or among grandparents, aunts, uncles and first cousins had any of the following diseases or problems? *(check if yes)*

- ___ Thyroid disease of any type
- ___ Congenital abnormalities – i.e. any defects present at birth or any disorders which “run in the family”
- ___ Infertility – i.e., difficulty getting pregnant for any reason.
- ___ Delayed puberty (didn’t shave; didn’t menstruate or develop breasts)
- ___ Breast, ovarian, or endometrial cancer

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms? (*check if yes*)

- Weight change
- Fatigue
- Change in vision
- Difficulty swallowing
- Chest pain
- Racing or irregular heartbeat
- Fainting or blackout spells
- Shortness of breath
- Snoring
- Nausea
- Constipation
- Diarrhea
- Vomiting
- Urinary incontinence
- Neck or back pain
- Muscle aches or cramps
- Joint pain
- Rash or skin lesion
- Headaches
- Numbness or tingling
- Dizziness
- Thoughts of Suicide
- Anxiety / Excessive worrying
- Depression
- Feeling excessive cold or warmth
- Excessive bleeding or bruising
- Runny nose
- Sore throat
- Cough
- Pain. Location _____
- Other _____