AUSTIN CENTER FOR
MEN'S HEALTH
A division of Austin Fertility & Reproductive Medicine

Male Fertility Questionnaire

Name: _____ Age: _____

Age of female partner: _____

Who referred you/how did you hear about us?
Dr. _____ or
Magazine _____ or
Internet _____ or
Friend/Family _____ or

History of Present Illness:
How long have you been trying to achieve a pregnancy? _____

(Yes / No – Circle Answer)

Has your female partner ever been pregnant before?	Yes / No
Have you previously conceived with your current partner?	Yes / No
Have you previously conceived with another woman?	Yes / No
Have you ever been evaluated for infertility before?	Yes / No
Have you had any severe illness, surgery, or fevers in the last 3-6 months?	Yes / No
Has your female partner had any pelvic infections or pelvic surgery in the past?	Yes / No
Does your female partner have regular menstrual cycles?	Yes / No
Is your female partner being seen by a fertility specialist?	Yes / No
Have you ever had surgery to fix a hernia as a child or as an adult?	Yes / No

Do you have or have you ever had an undescended testicle?	Yes / No
Have you ever had testicular torsion (twisting of the testicle)?	Yes / No
Have you had previous injury to your testicles or penis requiring hospitalization or surgery?	Yes / No
Have you ever had any sexual transmitted diseases?	Yes / No
If so what?	
Did you have the mumps after puberty?	Yes / No
Do you feel fatigued?	Yes / No
Have you had any unintentional weight loss?	Yes / No
Do you have any difficulty achieving or maintaining an erection?	Yes / No
Do you have a low sex drive or low desire for sex?	Yes / No
Does your urine ever look cloudy after sex?	Yes / No
How often are you having sex (times per week)?	_____
Do you ever use lubricants during sex?	Yes / No
If so what type?	_____
Do you use hot tubs regularly?	Yes / No
When using a laptop computer, do you rest it on your lap?	Yes / No
Do you have scrotal or testicular pain?	Yes / No
Do you have difficulty with your peripheral vision?	Yes / No
Do you have a poor sense of smell?	Yes / No
Do you ever have drainage or leakage from the nipples?	Yes / No
Do you have a cough you can not get rid of?	Yes / No
Have you had a semen analysis?	Yes / No
Have you had a vasectomy?	Yes / No

Have you had surgery for a varicocele? Yes / No

Past Medical History:
List any medical problems:

Medications:
List any medications that you take (include prescription, over the counter, herbs, supplements) and doses if known:

Past Surgical History:
List any surgeries that you have had:

Allergies:
List any medicines that you are allergic to that you know of and what type of reaction you had to that medication:

Family History:
Have any blood relatives had issues with infertility or required assisted reproductive techniques? Yes / No

Have any blood relatives been diagnosed with cystic fibrosis? Yes / No

Social History:
Do you smoke? Yes / No

If so how many cigarettes per day and how many years have you been smoking? _____

Do you drink alcohol? Yes / No

If so how many drinks do you have? _____

Do you smoke marijuana? Yes / No

Do you use any other illicit drugs? Yes / No

Are you married? Yes / No

Spouse/Partner's full name: _____

What is your occupation? _____

Are you exposed to any chemicals or toxins at work? Yes / No

Review of Systems:

General:
Have you had any fevers, change in weight, or weakness?

Dermatologic:
Have you had any change in skin, hair or nails?

Pulmonary:
Have you had any cough, wheezing, or difficulty breathing?

Endocrine:
Have you had any heat or cold intolerance or any excess hair growth?

Cardiovascular:
Have you had any chest pain, feeling of your heart skipping beats, or swelling in your legs?

Neurologic:
Have you had any seizures, tremors, or numbness?

Psychologic:
Have you had any depression, anxiety, or lack of interest in doing things that you used to enjoy?

Hematologic:
Do you bruise or bleed easily? Have you been diagnosed with anemia?

Gastrointestinal:
Do you have nausea, diarrhea, or constipation?

Genitourinary:
Do you have blood that you can see in your urine, difficulty urinating, or burning when you urinate?

Patient's signature_____ Date _____