

Medical Questionnaire

The following questionnaire is designed to help your physician evaluate you. All of the questions may not apply to you. Please circle or fill in the appropriate answer. If you have any additional information or comments you may write them in the additional space provided.

Date: _____

Name: Patient _____ Age _____

Spouse/Partner _____ Age _____

Occupation: Patient _____

Spouse/Partner _____

Fertility History

Are you currently married?

What is the duration of your current marriage?

How long have you been attempting to initiate a pregnancy?

Have you been involved in any previous pregnancies in this current marriage?

If yes, list age and gender.

Have you been previously married?

Did any pregnancies result in that marriage?

If yes, list age and gender.

Have you been previously evaluated or treated for infertility?

(If yes) When?

By Whom?

What treatment was performed?

Has your spouse/partner been evaluated for infertility?

(If yes) When?

By Whom?

What tests have been performed?

Childhood

As a child did you have any of the following:

*Undescended testicles?

If yes, what side? _____ Was it corrected with surgery? _____

Testicular torsion?

*Hernia surgery?

If yes what side? _____

*Mumps?

If yes, did it involve the testicles?

Did it occur after puberty?

*Bladder surgery?

*Hypospadias surgery?

Medical History

Do you have any medical problems?

If yes, please list.

Do you take any medications?
If yes, please list.

Are you allergic to any medications?
If yes, please list.

Do you have or have you ever had problems with:

Chronic respiratory infections?
Loss of sense of smell?

Surgical History

Have you had any previous operations?
If yes, please list.

Infections

Have you had any previous infections of the following?
(If yes, please describe treatment and give dates)

- *Kidneys?
- *Prostate?
- *Testicles?
- *Epididymis?
- *Urethra?

Have you had exposure in the last six months to:

- *Pesticides?
- *Chemotherapy?
- *Anabolic steroids?
- *High temperatures?
- *Radiation treatment?

Social History

Do you currently consume alcohol?
If yes, how much per week

Do you presently use:

- *Cigarettes?
- *Marijuana?

If yes, amount per day. _____

Family History

How many brothers do you have? _____ sisters? _____

Does anyone in your family have a history of

*Infertility? _____ *Cystic Fibrosis? _____ *Hormone imbalance? _____