

Male Fertility Clinic Questionnaire

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Urologist

You have been referred to the Infertility Clinic. We would ask that you please fill in the following questionnaire as completely and accurately as possible before you see the doctor. All provided information will remain confidential. It will be released only with your written permission and will be used to help us treat you.

Today's Date: ____/____/____
(DD/MM/YYYY)

Name: _____, _____
(Last Name) (First Name)

DOB: ____/____/____
(DD/MM/YYYY)

Referring MD: _____

Occupation: _____ Number of years at current job: _____

Previous occupation: _____

Partner's Name: _____, _____
(Last Name) (First Name)

DOB: ____/____/____
(DD/MM/YYYY)

Gynecologist work up: Y / N

By Doctor: _____

Pregnancy with current partner: Y/N

If Yes, did pregnancy result in a child: Y/N If Yes, children's ages: ____/____/____/____

With your current partner:

How long have you had unprotected sex not resulting in pregnancy? _____ years

How often do you have sex? ____/month

Ejaculation Painful: Y/N

Semen: White/Yellow/Brown/Red

More semen when younger: Y/N

Erection problems: No/ Sometimes/ Mostly/ Always

Urination painful after sex: Y/N

Urine cloudy after sex: Y/N

Contraception:

Never Used / Birth Control Pill / Intrauterine Device / Condom / Diaphragm / Other _____

Date when contraception last used _____

Sexual Aids: Y/N Type: _____

Sexual lubricants: Y/N Type: _____

Pregnancy with a previous partner: Y/N

If Yes, did pregnancy result in a child: Y/N If Yes, children's ages: ____/____/____/____

Urological History

Were you ever told as a child that you had:

Only 1 testis: Y/N

No testis: Y/N

Have you ever had a catheter (tube) put in your penis to the bladder: Y/N

Developed body hair at age: _____

Infections *(Please circle Y or N, and fill in the appropriate blanks if Yes)*

Gonorrhea Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Syphilis Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Herpes Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Genital warts Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Chlamydia Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Bladder Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Prostate Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Testis Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Penis Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Other _____

Previous Infertility Treatment

Antibiotics: Y/N

Clomid: Y/N

Hormones: Y/N

Other: _____

IUI (artificial insemination)/Sperm Wash Y/N

If Yes, Date: _____/_____/_____/_____/_____ Name of clinic: _____

IVF (in vitro fertilization)/ICSI (intracytoplasmic sperm injection) Y/N

If Yes, Date: _____/_____/_____/_____/_____ Name of clinic: _____

Past Surgical History *(Please circle Y or N, and fill in the appropriate blanks if Yes)*

Hernia: L/R/Both Sides/No Date: _____/_____

Undescended Testes L/R/Both Sides/No Date: _____/_____

Vasectomy Yes / No Date: _____

Abdominal/Pelvic Surgery Yes / No Date: _____

Vasovasostomy (Vasectomy Reversal) L/R/Both Sides/No Date: _____

Vasoepididymostomy L/R/Both Sides/No Date: _____

Testicular Biopsy L/R/Both Sides/No Date: _____

MicroTESE L/R/Both Sides/No Date: _____

Varicolectomy L/R/Both Sides/No Date: _____

Other _____/_____

Lifestyle

Smoking Y/N <1 / 1 / 2 / ≥2 pack(s) per day
Alcohol Y/N <1 / 1 / 2 / 3 / ≥4 drinks/per day
Marijuana Used in last six months? Y/N
Cocaine Used in last six months? Y/N
Other Used in last six months? Y/N Type _____

Family History

Other members with fertility problems Y/N
Relationship _____ Type _____
Relationship _____ Type _____

Medical History

Chemotherapy Y/N If Yes, how many years ago _____
Frequent colds Y/N (more than twice a year)
Pneumonia Y/N If Yes, How many times _____
Diabetic Y/N
Allergies _____
Other illness _____ / _____
Medications used in the last six months: _____

Androgen (Male Hormone) Deficiency and Sexual Dysfunction Questionnaire

Your age: _____

1. Do you have a decrease in libido (sex drive)? Yes No
2. Do you have a lack of energy? Yes No
3. Do you have a decrease in strength and/or endurance? Yes No
4. Have you lost height? Yes No
5. Have you noticed a decreased enjoyment of life? Yes No
6. Are you sad and/or grumpy? Yes No
7. Are your erections less strong? Yes No
8. Have you noted a recent deterioration in your ability to play sports? Yes No
9. Are you falling asleep after dinner? Yes No
10. Has there been a recent deterioration in your work performance? Yes No

Sexual Health Inventory for Men (SHIM)

Over the past 6 months:

1. How do you rate your confidence that you could get and keep an erection?
 1. Very low
 2. Low
 3. Moderate
 4. High
 5. Very High

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?
 0. No sexual activity
 1. Almost never or never
 2. A few times (much less than half the time)
 3. Sometimes (about half the time)
 4. Most times (much more than half the time)
 5. Almost always or always

3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?
 0. Did not attempt intercourse
 1. Almost never or never
 2. A few times (much less than half the time)
 3. Sometimes (about half the time)
 4. Most times (much more than half the time)
 5. Almost always or always

4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
 0. Did not attempt intercourse
 1. Extremely difficult
 2. Very difficult
 3. Difficult
 4. Slightly difficult
 5. Not difficult

5. When you attempted sexual intercourse, how often was it satisfactory for you?
 0. Did not attempt intercourse
 1. Almost never or never
 2. A few times (much less than half the time)
 3. Sometimes (about half the time)
 4. Most times (much more than half the time)
 5. Almost always or always

Total score: _____ (N>21)

Female Partner Information

Name: _____, _____ DOB: ____/____/____
(Last Name) (First Name) (DD/MM/YYYY)

Gynecologist work up: Y / N By Doctor: _____

Pregnancy with a previous partner: Y/N

If Yes, did pregnancy result in a child: Y/N If Yes, children's ages: ____/____/____/____

Age of first menstruation: _____

Average menstrual cycle duration: _____ days Average period duration: _____ days

Periods regular: Y/N Explain: _____

Recent fertility medications: Y/N

Type: _____ Started: _____ Stopped: _____

Type: _____ Started: _____ Stopped: _____

Type: _____ Started: _____ Stopped: _____

Gynecological surgery:

Laparoscopy Yes / No Date: _____/_____/_____

Scrape Uterus Yes / No Date: _____/_____/_____

Operation on Cervix Yes / No Date: _____/_____/_____

Remove Ovary L/R/Both Sides/No Date: _____/_____/_____

Remove Tube L/R/Both Sides/No Date: _____/_____/_____

Repair Tube L/R/Both Sides/No Date: _____/_____/_____

Other _____/_____

Infections: *(Please circle Y or N, and fill in the appropriate blanks if Yes)*

Gonorrhea Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Syphilis Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Herpes Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Genital warts Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Chlamydia Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Bladder Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Kidney Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Cervical Y/N Date: _____/_____/_____ Treatment: _____/_____/_____

Other _____

Medications used in the last six months: _____
