MALE FERTILITY QUESTIONAIRE

Date of first visit: / /20

Patient Name: Age: Date of Birth: / /19

Weight: (kg) Height: (cm)

Occupation:

Partner's Name: Partners Age: Date of Birth: / /19

1.	How long have you been actively attempting pregnancy? _____ Years _____ Months		
2.	Have you ever fathered any children before?	**Yes**	**No**
3.	Has Semen Analysis ever been abnormal?	**Yes**	**No**
4.	When you were a child, did your testes have to be surgically brought into scrotum? If yes, which side(s)? Rt. / Lt. How old were you? Years Old	**Yes**	**No**
5.	Have you ever had inguinal hernia operation?	**Yes**	**No**
6.	Have your ever had major trauma to your testicles?	**Yes**	**No**
7.	Did you go through puberty at the same time as your peers?	**Yes**	**No**
8.	Did you have mumps when you were a child?	**Yes**	**No**
9.	Have you ever been treated for a sexually transmitted infection?	**Yes**	**No**
10.	Have you ever used anabolic steroids or body-building drugs?	**Yes**	**No**
11.	Have you ever used Marijuana or any other recreational drugs? _____	**Yes**	**No**
12.	Do you have difficulties in having erection, ejaculation or sexual desire?	**Yes**	**No**
13.	Have you ever been exposed to a large amount of radiation, or chemotherapy?	**Yes**	**No**
14.	Are you allergic to any medications? If yes, what medications?	**Yes**	**No**
15.	Do / did you smoke cigarettes? If yes, how many cigarettes a day?	**Yes**	**No**
16.	Do you drink alcoholic beverages? If yes, how many drinks a week?	**Yes**	**No**
17.	Are you currently taking any medications on a regular basis? If yes, what medications?	**Yes**	**No**
18.	Have you previously had evaluation for male infertility?	**Yes**	**No**
19.	Is there any family history of inherited medical conditions?		
20.	Any other relevant information?		

I declare the above information to be complete and correct

Patient Signature: Printed Name: Date: / /20

Please complete this Questionaire and return it to reception or by email, fax or regular post.

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