



Dr Hossam Elzeiny

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MALE FERTILITY QUESTIONNAIRE

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 you 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 Questionnaire and return it to reception or by email, fax or regular post.