LIGHTHOUSE MISSION HOSPITAL AND FERTILITY CENTER

MALE FERTILITY QUESTIONNAIRE

Name……..... Age……..

Partner's full name …….. Age of partner……

Who referred you/how did you hear about us?

Friend……

Signboard……..

Other……

HISTORY OF PRESENT ILLNESS:

How long have you been trying to achieve a pregnancy? .....

Has your female partner ever been pregnant before? Yes/No/Don't know

Have you previously conceived with your current partner? Yes/No/Don't know

Have you previously conceived with another woman? Yes/No/Don't know

Have you ever been evaluated for infertility before? Yes/No/Don't know

Have you had any severe illness, surgery, or fever in the last 3-6 months? Yes/No/Don't know

Has your female partner had any pelvic infections or pelvic surgery in the past? Yes/No/Don't know

Does your female partner have regular menstrual cycles? Yes/No/Don't know

Is your female partner being seen by a fertility specialist? Yes/No/Don't know

Have you ever had a surgery to fix hernia as a child or as an adult? Yes/No/Don't know

Do you have or have you ever had an undescended testicle? Yes/No/Don't know

Have you ever had testicular torsion (twisting of the testicles) Yes/No/Don't know

Have you had previous injury to your testicles or penis requiring

hospitalization or surgery? Yes/No/Don't know

Have you ever had any sexually transmitted diseases? Yes/No/Don't know

If so what? .....

Did you have the mumps during puberty? Yes/No/Don't know

Do you feel very tired? Yes/No/Don't know

Have had any <u>unintentional</u> weight loss? Yes/No/Don't know

Do you have any difficulty achieving or maintaining an erection? Yes/No/Don't know

Do you have a low sex drive or low desire for sex? Yes/No/Don't know

Does your <u>urine</u> ever look cloudy after sex? Yes/No/Don't know

How often are you having sex (times per week)? ……..

Do you ever use lubricants during sex? Yes/No/Don't know

If so what type?

…….

When using a laptop computer, do you rest it on your lap? Yes/No/Don't know

Do you have scrotal or testicular pain? Yes/No/Don't know

Do you have a poor sense of smell? Yes/No/Don't know

Do you ever have drainage or leakage from the nipple? Yes/No/Don't know

Do you have a cough you cannot get rid of? Yes/No/Don't know

Have you had a semen analysis? Yes/No/Don't know

Have had a vasectomy? Yes/No/Don't know

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? Yes/No

Dermatologic:

Have you had any change in skin, hair or nails? Yes/No

Pulmonary:

Have you had any cough, wheezing or difficulty in breathing? Yes/No

Endocrine:

Have you had any heat or cold intolerance or any excess hair growth? Yes/No

Cardiovascular:

Have you had any chest pain, feeling of your heart skipping beats, or swelling in your legs? Yes/No

Neurologic:

Have you had any seizures, tremors or numbness? Yes/No

Psychologic:

Have you had any depression, anxiety or lack of interest in doing things that you used to enjoy? Yes/No

Hematologic:

Do you bruise or bleed easily? Have you been diagnosed with anemia? Yes/No

Gastrointestinal:

Do you have nausea, diarrhea or constipation? Yes/No

Genitourinary:

Do you have blood that you can see in your urine, difficulty urinating, or burning when you urinate? Yes/No

Have you had surgery for a varicocele? Yes/No

PAST MEDICAL HISTORY:

List any medical problems

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Medications:

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

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PAST SURGICAL HISTORY:

List any surgeries that you have had:

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Allergies:

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

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Family History:

Have any blood relatives had issues with fertility or required assisted reproductive

techniques? 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 drinks do you have? ……..

Do you smoke marijuana? Yes/No

Do you do illicit drugs?
Yes/No

Are you married?
Yes/No

PLEASE ATTEMPT TO ANSWER **ALL** THE QUESTIONS. FOR HELP IN ANSWERING ANY QUESTIONS DO SPEAK WITH OUR FERTILITY COUNSELLOR**, Mrs. Doris Nyarko – 026 549 1116**

PLEASE BRING THIS FORM WITH YOU TO YOUR FIRST APPOINTMENT.

ENSURE THAT ALL MEDICAL RECORDS AND LAB TESTS FROM CURRENT OR PAST DOCTORS ARE ALSO BROUGHT FOR YOUR APPOINTMENT.

WE LOOK FORWARD TO SEEING YOU.