

Confidential Questionnaire MALE HISTORY

NAME	AGE	DATE OF BIRTH	
ADDRESS			
HOME PHONE	WORK PHONE	PLACE OF EMPLOYMENT	OCCUPATION

MARITAL HISTORY

HAVE YOU BEEN MARRIED PREVIOUSLY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, HOW LONG?
DID A PREGNANCY OCCUR IN PREVIOUS MARRIAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	PLEASE LIST OUTCOME OF ANY PREGNANCIES

FEMALE HISTORY

	AGE	HEALTH/ IF LIVING	CAUSE OF DEATH/IF DECEASED
FATHER			
MOTHER			
SIBLINGS / NAMES:			

PRIOR FERTILITY WORKUP

HAVE YOU HAD ANY OF THE FOLLOWING? IF YES, PLEASE INDICATE THE DATE, THE PHYSICIAN WHO PERFORMED THE TEST, & RESULTS

	DATE	RESULT	PHYSICIAN
SEMEN ANALYSIS			
SPERM PENETRATION ASSAY			
UROLOGICAL EXAM			
SURGERIES			
MEDICATIONS			

MEDICAL HISTORY

DO YOU HAVE ANY SIGNIFICANT HEALTH PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DESCRIBE
ARE YOU ALLERGIC TO ANY MEDICATIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST NAME AND REACTION IT CAUSES
HAVE ANY OF YOUR RELATIVES HAD ANY HEALTH PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DESCRIBE <input type="checkbox"/> YES <input type="checkbox"/> NO

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MEDICAL HISTORY CONTINUED				
ANY HISTORY OF SEXUALLY TRANSMITTED DISEASE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DESCRIBE		
FREQUENCY OF INTERCOURSE PER WEEK?		ANY DIFFICULTIES WITH INTERCOURSE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
ANY DIFFICULTIES WITH EJACULATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		DO YOU TAKE HOT BATHS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DO YOU TAKE SAUNAS? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU HAD ANY OTHER "SERIOUS" ILLNESS NOT LISTED ABOVE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DESCRIBE		
DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, HOW MUCH AND FOR HOW LONG?		
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, HOW MANY DRINKS PER WEEK?		
DO YOU USE RECREATIONAL DRUGS NOW? IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST PAST: _____ NOW: _____		
DO YOU EXERCISE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE LIST TYPE OF EXERCISE AND HOW OFTEN		
WEIGHT:	HEIGHT:	MAXIMUM WEIGHT WHEN?	MINIMUM WEIGHT WHEN?	DOES YOUR WEIGHT FLUCTUATE? <input type="checkbox"/> YES, HOW MUCH? <input type="checkbox"/> NO
ANY RISK FACTORS FOR HIV? <input type="checkbox"/> YES <input type="checkbox"/> NO		HAVE YOU EVER USED IV DRUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO		HAVE YOU EVER HAD SEX WITH A BISEXUAL OR HOMOSEXUAL MALE? <input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU HAD A BLOOD TRANSFUSION BEFORE 1985? <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE YOU A HEMOPHILLIAC? <input type="checkbox"/> YES <input type="checkbox"/> NO		
<p><i>Thank you for taking the time to fill out this questionnaire.</i></p> <p>PLEASE USE THE SPACE BELOW TO ADD ANYTHING (NOT MENTIONED ABOVE) THAT YOU FEEL IS IMPORTANT TO YOUR HISTORY AND CARE</p>				