

UCSF Male Reproductive Health Questionnaire

To provide you with the best possible care, I would appreciate it greatly if you could fill out the following questionnaire concerning your health. There is also a section for your partner to complete concerning her health. All of the information will be held in strict confidence as it becomes a part of your medical chart. Please fax this to 415-885-3663 before your appointment.

Your Name: _____

Today's Date ____/____/____

Home Tel. #: (____) _____

Birth Date ____/____/____

Work/Day # (____) _____

Your age: _____

Email address: _____

Partner's Full Name: _____

Partner's age: _____

Preferred form of contact: Email Home Address

Telephone

REFERRING DOCTOR(S):

Yours: Dr. _____

And

Dr. _____

Tel: _____

Tel: _____

Partner's Doctor:

Dr. _____

Tel: _____

Please fax any pertinent lab results (such as hormones or ultrasounds) to 415-885-3663 before your scheduled appointment.

PRIVATE OFFICE: UCSF Ira Sharlip, MD	<input type="checkbox"/> NEW <input type="checkbox"/> RETURN
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Patient Information

FIRST NAME	LAST NAME	OCCUPATION
ADDRESS		EMPLOYER
CITY	STATE	ZIPCODE
HOME PHONE:		BUSINESS PH:
CITY		EMPLOYER ADDRESS
SOCIAL SECURITY #	BIRTHDATE / /	AGE:
SPOUSE'S NAME		BIRTHDATE / /

Health Insurance Information

PRIMARY CARRIER:		SECONDARY CARRIER:	
Insurance Name:		Insurance Name:	
Insurance Address:		Insurance Address:	
Insured's Name:	Relationship:	Insured's Name:	Relationship:
ID #		ID #	
Group Name and No.		Group Name and No.	
Insurance Telephone #		Insurance Telephone #	

REFERRING DOCTOR

Last Name	First Name
Address:	
City	State Zip
Phones:	

Assignment of Medical Benefits

I authorize payment of Medical Benefits to above stated physician for services described. I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits to the physician who accepts assignment.	
_____	_____
Patient's Signature	Date

QUESTIONS FOR HIM (Fill in the blank or circle word):

- | | | | |
|--|-------|----|--|
| 1. If married, number of years | _____ | | |
| 2. How many years trying to conceive? | _____ | | |
| 3. Prior pregnancies between you and your partner? (number) | _____ | | |
| 3a. Number of pregnancies carried to term and delivered | _____ | | |
| 3b. Number of miscarriages | _____ | | |
| 3c. Number of planned abortions | _____ | | |
| 4. Number of pregnancies between you and another partner | _____ | | |
| 4a. Number of pregnancies carried to term and delivered | _____ | | |
| 4b. Number of miscarriages | _____ | | |
| 4c. Number of planned abortions | _____ | | |
| 5. Method of birth control, if used in past _____ | | | |
| 5a. How many times each week (on average) do you have intercourse? | _____ | | |
| 6. Type of lubricant, if used _____ | | | |
| 7. Have you had prior infertility treatments? | Yes | No | |
| 8. Do any of the following concern you? | | | |
| 8a. Your ability to get an erection | Yes | No | |
| 8b. Your ability to maintain an erection | Yes | No | |
| 8c. Ejaculating before your partner is ready | Yes | No | |

MEDICAL HISTORY

- | | | | |
|--|-----|-----|--|
| 9. Have you ever been told (or know) that you have any of the following? | | | |
| 9a. Undescended testicles at birth? | Yes | No | |
| 9b. If you had undescended testes, which side(s)? | L__ | R__ | |
| 9c. Mumps after puberty with painful testes? | Yes | No | |
| 9d. Diabetes mellitus | Yes | No | |
| 9e. Cancer | Yes | No | |
| 9f. Multiple sclerosis | Yes | No | |
| 9g. Other neurological problems | Yes | No | |
| 9h. Infection of the urine | Yes | No | |
| 9i. Infection of the prostate (prostatitis) | Yes | No | |
| 9j. Infection of the epididymis (epididymitis) | Yes | No | |
| 9k. Venereal disease | Yes | No | |
| 9l. Green or yellow discharge from the penis | Yes | No | |
| 9m. Blood in your ejaculate | Yes | No | |
| 9n. Bothered by problems with urination | Yes | No | |
| 9o. Injury to the testicles that needed hospitalization | Yes | No | |
| 9p. Ulcers | Yes | No | |
| 9q. Kidney stones | Yes | No | |
| 9r. Pain in your scrotum or testes | Yes | No | |
| 9s. Lots of problems with bronchitis or pneumonias | Yes | No | |

9t. Any other medical problems (list below) Yes No

9u. Do you have **allergies or reactions** to medications you've taken Yes No

9v. If you have allergies to medications, please list these medications below:

SURGICAL HISTORY

10. Have you ever been told or remember any of the following?

- 10a. A hernia operation? Yes No
- 10b. If you had a hernia operation, which side(s)? L__ R__
- 10c. Any bladder or penis operation as a child? Yes No
- 10d. Pelvic or back surgery Yes No
- 10e. Testis surgery Yes No
- 10f. Surgery for varicoceles Yes No
- 10g. Surgery for hydroceles Yes No
- 10h. Surgery for scrotal cysts Yes No
- 10i. Vasectomy Yes No
- 10j Other infertility surgery Yes No

- TURED Yes No
- Sperm Aspiration Yes No
- Vasectomy reversal Yes No
- Epididymovasostomy Yes No
- Electroejaculation Yes No

10j. Any other surgery in the past (list below) Yes No

EXPOSURE HISTORY

11a. Please list the medications (doses too) that you take below:

- 11b. Do you smoke cigarettes (or cigars or pipes)? Yes No
- 11c. If/when you smoke(d), how long did you smoke? (years) _____
- 11d. If/when you smoke(d), how many cigs/cigars per day? _____
- 11e. If you quit smoking, how long has it been (years)? _____
- 11f. Do you use any of the following (circle one response)?
- | | | | |
|-----------|------|---------------|----------------|
| Alcohol | None | <2 drinks/day | >2 drinks/ day |
| Coffee | None | <2 cups/day | >2 cups/day |
| Soda | None | <2 cans/day | >2 cans/day |
| Marijuana | None | Infrequent | Frequent |
- 11g. What do you do for work? _____
- 11h. Do you travel alot for work? Yes No
- 11i. Do you consider your job stressful? Yes No
- 11j. If stressful, can you rate it Low Moderate High Extreme
- 11k. Any radiation or harmful chemicals on the job? Yes No
- 11L If yes to above, please list the exposure and when?
- | Agent | Year |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
- 11m. Any exposure to prolonged heat in work/hobbies? Yes No
- 11n. Any pesticide exposure? Yes No
- 11o. Do you use hot tubs, saunas or jacuzzi's? Yes No
- How often? (circle one)
- Every day
Every other day
Once a week
Occasionally

ENDOCRINE HISTORY/REVIEW OF SYSTEMS

12. Do you have (or have you ever had) any of the following?
- 12a. Difficulty with smell? Yes No
- 12b. Difficulty with vision (besides needing glasses)? Yes No
- 12c. Changing skin color (not tanning related)? Yes No
- 12d. Problems with growth when you were young? Yes No
- 12e. Did your voice change later than your friends'? Yes
No
- 12f. How often do you need to shave? _____ Once a day
_____ Once every other day
_____ Twice a week or less
- 12g. Has your shaving pattern changed recently? Yes No
- 12h. Any tenderness to your breasts? Yes
No
- 12i. Fevers in the last 3 months Yes No

FAMILY HISTORY

13. Concerning the rest of your family:

- 13a. How many blood related brothers do you have? _____
- 13b. How many blood related sisters do you have? _____
- 13c. Have any of your brothers or sisters had troubling having children? Yes No
If yes: who? _____ what problem? _____
- 13d. Are there any adopted children in your family? Yes No
If so, who has adopted children? _____
- 13e. Any miscarriages in the immediate family? Yes No
- 13f. Did your mother ever take DES (diethylstilbesterol)? Yes No
- 13g. Did your parents have troubling conceiving you or your
brothers or sisters? Yes No

QUESTIONS FOR HER (Fill in the blank or circle the word):

- 14a. How many blood related brothers do you have? _____
- 14b. How many blood related sisters do you have? _____
15. Is this your first marriage? Yes No
16. Number of pregnancies between you and another partner _____
16a. Number of pregnancies carried to term and delivered _____
16b. Number of miscarriages _____
16c. Number of planned abortions _____
17. Do you have any medical problems? Yes No
If so, please list them: _____

18. Have you been evaluated for infertility in the past? Yes No

19. Do you have regular menstrual cycles? Yes No

20. Which of the following tests do you remember having done?

	Yes	No	Can't Remember	Result
Basal Body Temps	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Blood tests	_____	_____	_____	_____
Post-coital test	_____	_____	_____	_____
Hysterosalpingogram	_____	_____	_____	_____
Laparoscopy	_____	_____	_____	_____

21. Which of the following treatments have you had to date?

	Yes	No	When?
Clomid	_____	_____	_____
IUI	_____	_____	_____
IVF	_____	_____	_____
IVF/ICSI	_____	_____	_____
GIFT	_____	_____	_____

22. Do other family members have infertility or problems in conceiving? Yes No
 If yes: who? _____ what problem? _____

GENETIC INFERTILITY SCREENING

23. Do you or your partner have any of the following ancestry?

	YOU			PARTNER	
	yes	no		yes	no
Asian/ Asian American	yes	no		yes	no
Caucasian	yes	no		yes	no
Southern European	yes	no		yes	no
Northern European	yes	no		yes	no
African/African American	yes	no		yes	no
Ashkenazi Jewish	yes	no		yes	no
Cajun/French Canadian	yes	no		yes	no
Hispanic/Caribbean	yes	no		yes	no

24. If you have children:

24a. Are they healthy?

Together **A previous partner** **Your partner/ a previous partner**
 yes no yes no yes no

24b. Do they have birth defects, genetic condition or severe medical problems?

Together **A previous partner** **Your partner/ a previous partner**
 yes no yes no yes no

If yes, please describe: _____

24c. Do they have developmental delay, learning disabilities or mental retardation?

Together **A previous partner** **Your partner/ a previous partner**
 yes no yes no yes no

If yes, please describe: _____

25. Do you, your partner or blood relatives have one of the following disorders?

	YOU		Partner		Family		Who?
	yes	no	yes	no	yes	no	
Never began menstruation	yes	no	yes	no	yes	no	
Early menopause	yes	no	yes	no	yes	no	
Recurrent miscarriages (3 or more)	yes	no	yes	no	yes	no	
Stillborn baby or baby died < 1year old	yes	no	yes	no	yes	no	
Cystic fibrosis	yes	No	yes	no	yes	no	
Tay-Sachs or Canavan disease	yes	no	yes	no	yes	no	
Muscular disorders	yes	no	yes	no	yes	no	
Neurological disorders	yes	no	yes	no	yes	no	
Bone/skeletal disorder (e.g.dwarfism)	yes	no	yes	no	yes	no	
Birth defect (e.g. cleft palate, hip dislocation)	yes	no	yes	no	yes	no	
Developmental delay, learning disability or mental retardation	yes	no	yes	no	yes	no	
Polycystic Kidney disease	yes	no	yes	no	yes	no	
Heart defect from birth	yes	no	yes	no	yes	no	
Down Syndrome	yes	no	yes	no	yes	no	
Sex chromosome abnormality (e.g. Klinefelter/Turner Sundrome)	yes	no	yes	no	yes	no	
Other chromosomal abnormalities	yes	no	yes	no	yes	no	
Marfan Syndrome	yes	no	yes	no	yes	no	
Bleeding disorders (e.g.hemophilia)	yes	no	yes	no	yes	no	
Sickle cell anemia, Thalassemia	yes	no	yes	no	yes	no	
Deafness / blindness (at birth or early onset)	yes	no	yes	no	yes	no	

26. Are you concerned someone in your or your partners' family has a genetic condition that put's you or your offspring at risk? _____

27. Did you have any problems in filling out this questionnaire? yes no
If yes, why? _____

Thank you very much for filling out this questionnaire.