

Date: / /

**Duke University Medical Center
Division of Reproductive Endocrinology and Fertility**

Male Fertility Initial Questionnaire & Medical History Intake Form

Male Patient Name: _____

Partner (female) name: _____

SSN or History #: _____

Date of Birth: _____

Height: _____ Weight: _____

Race: _____ Hispanic or Latino: Yes No

Phone (day): _____

Education level: _____

Phone (night): _____

Occupation: _____

Email: _____

MEDICAL HISTORY

Current Medications: _____

Please indicate if you have had medical problems with any of the following areas:

Body System	Yes	No	Year	Currently?	Description/Medication
Skin	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Head, eyes, ears, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Lungs (including tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Heart or blood vessels (including high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Stomach/intestines	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Liver	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Hormones / metabolism (including diabetes, thyroid disorder, abnormal puberty)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Nervous system/brain function	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Psychiatric condition	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Hematologic/Lymphatic (including anemia, transfusion)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Muscles/bones	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Allergies (include medication allergies and reaction when taken)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Infection with fever in past year	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Sexually transmitted diseases: Chlamydia, Hepatitis B or C, Gonorrhea, Syphilis, Other	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Childhood Diseases: Chicken pox, Measles, Mumps, Other	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Cancer (include type of cancer, chemo, radiation and where radiation directed)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Urological problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Other major illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

SURGICAL HISTORY

	Yes	No	Year	Description
When younger, did your testes have to be surgically brought to your scrotum?	<input type="checkbox"/>	<input type="checkbox"/>		N/A
Have you had a hernia repair?	<input type="checkbox"/>	<input type="checkbox"/>		Right side / Left side / Both sides
Have you had surgery to improve fertility?	<input type="checkbox"/>	<input type="checkbox"/>		
When younger, did your testes ever twist (torsion) requiring surgery to untwist?	<input type="checkbox"/>	<input type="checkbox"/>		Right side / left side / Both sides
Have you ever had a varicocele repair?	<input type="checkbox"/>	<input type="checkbox"/>		One side / Both sides
Have you experienced major trauma to your testes?	<input type="checkbox"/>	<input type="checkbox"/>		
Bladder surgery	<input type="checkbox"/>	<input type="checkbox"/>		
Prostate surgery	<input type="checkbox"/>	<input type="checkbox"/>		
Other surgery:	<input type="checkbox"/>	<input type="checkbox"/>		

SEXUAL HISTORY

Have you ever had...	Yes	No
Difficulty achieving an erection	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty maintaining an erection	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>
Pain with ejaculation	<input type="checkbox"/>	<input type="checkbox"/>
Blood in your ejaculation	<input type="checkbox"/>	<input type="checkbox"/>

How often do you have intercourse?	# times _____ Per week / Per month
How often do you have sexual activity?	# times _____ Per week / Per month

MALE INFERTILITY HISTORY

Please list all pregnancies with current or prior partner (s) :

Pregnancy	Complication (if yes, describe)	Malformation (if yes, describe type and if with current or prior partner)
1		
2		
3		
4		
5		

How long have you and your partner been trying to conceive? _____

Have you ever had any types of fertility problems? Yes No

If Yes, explain briefly what type of problem and what treatment has been done? _____

Have you ever had a semen analysis? Yes No

If Yes, results?

Date	Volume	Count	Motility	Morphology	Other

Have you been tested for Antisperm Antibodies? Yes No If Yes, results? _____

Have you ever taken any Fertility Medications? If Yes, note for how long

	Yes	No		Yes	No
Clomid			Aromatase injections		
Gonal F			Anastrozole		
Bravelle			Testolactone		
Follistim			Other		
HCG or LH injections					

Have you been diagnosed with any of the following **genetic** conditions?

- | | | |
|-----------------------------|-----|----|
| Cystic Fibrosis | Yes | No |
| Klinefelters | Yes | No |
| Y chromosome microdeletions | Yes | No |
| Other _____ | Yes | No |

EXPOSURE HISTORY/ FAMILY HISTORY

Type	Yes	No	How often and last occurrence
Hot baths	<input type="checkbox"/>	<input type="checkbox"/>	
Sauna	<input type="checkbox"/>	<input type="checkbox"/>	
Whirlpool	<input type="checkbox"/>	<input type="checkbox"/>	
Work chemicals or pesticides	<input type="checkbox"/>	<input type="checkbox"/>	
Large amounts of radiation	<input type="checkbox"/>	<input type="checkbox"/>	
Lengthy exposure to radiation	<input type="checkbox"/>	<input type="checkbox"/>	
Current smoker	<input type="checkbox"/>	<input type="checkbox"/>	# per day _____ # Years smoking _____
Past smoker	<input type="checkbox"/>	<input type="checkbox"/>	Year quit _____ # Years _____ # per day _____
Coffee / caffeinated drinks	<input type="checkbox"/>	<input type="checkbox"/>	# per day _____
Marijuana (current / past)	<input type="checkbox"/>	<input type="checkbox"/>	How often _____
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	Type _____ frequency _____
Anabolic steroids / body building drugs	<input type="checkbox"/>	<input type="checkbox"/>	Type _____ frequency _____
Alcoholic beverages	<input type="checkbox"/>	<input type="checkbox"/>	# per week _____
Current calorie restricting diet	<input type="checkbox"/>	<input type="checkbox"/>	If yes, daily caloric intake _____
Regular exercise	<input type="checkbox"/>	<input type="checkbox"/>	if yes, type and frequency _____
Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>	if yes, lb lost _____ timeframe _____
Current vitamins, supplements, herbals	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type _____ frequency _____
Any blood relatives with fertility issues?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, who: _____
Did your mother take DES when pregnant with you?	<input type="checkbox"/>	<input type="checkbox"/>	DES is a tablet that was given to women with a history of miscarriage or bleeding during pregnancy

Do you have a family history of any of the following: (circle all that apply)

- | | | |
|----------------------|---------------------|---------------------|
| Birth defects | Down Syndrome | Muscular Dystrophy |
| Brain/Spinal defects | Fragile X Syndrome | Sickle Cell Disease |
| Cancer | Heart Disease | Tay Sachs Disease |
| Cystic Fibrosis | Hemophilia | Thalassemia |
| Diabetes | High Blood Pressure | Thyroid Disease |

If yes, who: _____

Are you from any of these ethnic backgrounds: (circle all that apply)

- | | | | | |
|------------------|-----------------------|-----------|------------------|--------------|
| Italian | Jewish | Caucasian | African American | Other: _____ |
| Greek | French Canadian/Cajun | | African | |
| Middle Eastern | | | Hispanic | |
| Spanish | | | | |
| Southern Chinese | | | | |
| Asian Indian | | | | |
| Taiwanese | | | | |
| Filipino | | | | |
| Southeast Asian | | | | |

If yes, have you had any specific genetic testing to see if you are a carrier of a genetic disease? _____

Are there any other issues you would like to share with us?

Thank you very much for completing this questionnaire.