

BRANDEIS FERTILITY PROGRAM

Questionnaire for Husband

General Information

Date: _____

Name _____ Wife's Name _____

Address _____

Home Phone Number _____ Work Phone _____ Cell Phone _____

Birth date _____ Age _____ Occupation _____

What is your Ethnic Background ?

<input type="checkbox"/> White non- Hispanic	<input type="checkbox"/> White Hispanic	<input type="checkbox"/> Black non-Hispanic	<input type="checkbox"/> Black Hispanic
<input type="checkbox"/> Asian non-Hispanic	<input type="checkbox"/> Asian Hispanic	<input type="checkbox"/> Native American	<input type="checkbox"/> Other

Height _____ Weight _____ Blood Type _____ Highest Education _____

Name of Urologist	Name of Primary Care Physician
Name:	
Address:	
Phone:	
Fax:	

Please send information regarding my care
Signature: _____

Please send information regarding my care
Signature: _____

Referred by: Physician Name: _____
Address: _____
Phone: _____
Fax: _____

Please send information regarding my care
Signature: _____

Referred by: _____

Sexual History

- Has there been any change in your sexual drive? No Yes If Yes, please explain: _____
- Do have any difficulty in maintaining an erection? No Yes If Yes, please explain: _____
- Do you ejaculate into the vagina with difficulty? No Yes If Yes, please explain: _____
- Do you have burning or pain with ejaculation or urination? No Yes If Yes, please explain: _____
- Did you ever notice any discharge from your penis? No Yes If Yes, please explain: _____
- Frequency of sexual intercourse per week? _____
- Have your genitals ever been exposed to excessive heat? No Yes If Yes, please explain: _____
- Have you had any serious injuries to your genitals? No Yes If Yes, please explain: _____
- Is there any history of birth defects in your family? No Yes If Yes, please explain: _____
- Is there any history of recurring miscarriages in your family? No Yes If Yes, please explain: _____

Have you ever been treated for:

	Date	Comments
Syphilis	_____	_____
Gonorrhea	_____	_____
Chlamydia (non-specific urethritis)	_____	_____
Prostatitis (infection of the prostate)	_____	_____
Infection of the testicles	_____	_____
Infection of the seminal vesicles	_____	_____
Genital Herpes	_____	_____

Medical History	Yes	No	Dates/Comments
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles (Regular)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles (German)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elevated Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Parasitic Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nongonoccal Urethritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver or gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis (A, B, C)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary tract abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Auto immune diseases: (lupus, rheumatoid arthritis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other serious or chronic diseases:

Do you have any allergies to medications: No Yes

If yes, which medications:

Have you taken prescription medications – Example: Antidepressants, Ulcer Medication, Hypertensive Medications, etc. ?

If yes, please indicate:

Medication	Diagnosis	Dosage / Frequency	When Taken	Comments

Surgical History

Date	Procedure	Findings	Hospital	Surgeon

Any history of radiation treatment or anti-cancer drugs? No Yes

If Yes, please explain:

Have you ever been involved in psychotherapy or counseling? No Yes

If yes, please indicate why, when, with whom, and any other pertinent information.

Please fill in a review of any current or recent symptoms:

	Yes	No		Yes	No		Yes	No
Chronic headaches	___	___	Increased thirst	___	___	Excessive Fatigue	___	___
Head injury	___	___	Increased sweating	___	___	Tremors	___	___
Seizures	___	___	Intolerance to heat	___	___	Desire for extra salt	___	___
Eyesight problems	___	___	Intolerance to cold	___	___	Balding	___	___
Dizziness	___	___	Difficulty swallowing	___	___	Change in voice / hoarseness	___	___
Acne	___	___	Change of appetite	___	___	Difficulty sleeping	___	___

Have you lost or gained greater than 10 lbs of weight in the last year? No Yes

If Yes, please explain:

Do you follow a particular food diet or have any special dietary habits? No Yes

If Yes, please specify:

Have you ever had an eating disorder (anorexia or bulimia)? No Yes

If Yes, please specify:

Please include any other information which you believe may be pertinent to your infertility problem:

Occupation/Leisure History

Dates/Comments

Have you been exposed to chemical or x-rays in work or hobby? No Yes

At work, are you exposed to high temperatures? No Yes

Do you drive long distances? No Yes

Do you frequently use saunas or hot tubs? No Yes

Do you or have you ever used? (check all that apply):

Alcohol – How many glasses per week do you usually drink? _____ Wine Beer Cocktails

Cigarettes – Number of packs / day _____ Number of years smoking _____ Year Stopped Smoking: _____

Recreational Drugs (Marijuana, Cocaine, etc.) Specify: _____

Nutritional Supplements, herbs, etc. Specify: _____

Please describe exercise activities (days per week, length of time, etc.) :

Family History

Father's age if alive _____ If no longer living, cause of death: _____

Medical problems: _____

Mother's age if alive _____ If no longer living, cause of death _____ Age at menopause _____

Medical problems: _____

Sister(s) ages _____

Medical problems: _____

Brother(s) ages _____

Medical problems: _____

Did your mother have any difficulty with conception or pregnancy? No Yes

Did your mother take any medications (ex. Diethylstilbestrol) while pregnant with you? No Yes Don't Know

If Yes, please specify? _____

Does anyone in your family have:	Yes	No	Relationship / Comments
Birth defects or genetic diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polycystic Ovaries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Miscarriages/stillbirths	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pregnancy problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/endocrine problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other hormonal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any women who have never menstruated	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any men who have never had to shave	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any additional comments you would like to make that you feel may be pertinent and have not already been addressed:

Infertility History

Have you ever fathered a pregnancy? No Yes

Number conceived with current partner? _____

Number conceived with previous partners? _____

Date	Delivered	Aborted	Miscarried	Difficulty Conceiving?

FERTILITY HISTORY

Pre-conceptual Health Screening

Have you ever been tested for:	Yes	No	Date:	If yes, give results
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
TB (Tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood Type	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gaucher Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Canavan Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sickle cell	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anemia or Thallasemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Previous Infertility Testing

How many months/ years have you had unprotected intercourse? _____

Additional Information: _____

How many months / years have you been trying to get pregnant? _____

Additional Information: _____

Which physician have you seen for evaluation or treatment of infertility?

Name: _____

Address: _____

Phone: _____ Fax: _____

What causes for infertility was found?

Previous urological exam? yes no

Results: _____

Have you had semen analysis testing? yes no

Date	Lab	Count	Motility	Morphology	Comments

Have you been evaluated for varicocele? No Yes

Date	Physician	Findings

Have you had a Doppler study? (sonogram or ultrasound of the testicle?) No Yes

Have you had a varicocele repair? No Yes If Yes, please explain: _____

Specialized sperm testing? No Yes

Results: _____

Acrosome reaction No Yes

Results: _____

Sperm penetrating assay No Yes

Results: _____

Antibody testing No Yes

Results: _____

- END -