

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:	

Referred by: Physician Name: _____

Address: _____

Phone: _____ - _____

Fax: _____

 Please send information regarding my care

Sexual History

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

Have you ever been treated for:

		Date	Comments
Syphilis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Gonorrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Chlamydia (non-specific urethritis)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Prostatitis (infection of the prostate)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Infection of the testicles	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Infection of the seminal vesicles	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____
Genital Herpes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	_____

Medical History **No** **Yes**

- Mumps No Yes
- Measles (Regular) No Yes
- Measles (German) No Yes
- Rheumatic fever No Yes
- Scarlet fever No Yes
- Tuberculosis No Yes
- Elevated Blood pressure No Yes
- Heart murmur No Yes
- Heart disease No Yes
- Diabetes No Yes
- Lung disease No Yes
- Ulcers No Yes
- Appendicitis No Yes
- Colitis No Yes
- Anemia No Yes
- Poor sense of smell No Yes

Medical History **No** **Yes**

- Chronic headaches No Yes
- Blood Transfusion No Yes
- Parasitic Infection No Yes
- Nongonoccal Urethritis No Yes
- Liver or gall bladder disease No Yes
- Jaundice No Yes
- Kidney infections No Yes
- Hepatitis (A, B, C) No Yes
- Kidney stones No Yes
- Gout No Yes
- Urinary tract abnormalities No Yes
- Thyroid disease No Yes
- Neurological Problems No Yes
- Arthritis No Yes
- Auto immune diseases (lupus, etc) No Yes
- Loss of balance No Yes

Other conditions and comments _____

Do you have any allergies to medications: No Yes

If yes, which medications: _____

Have you taken prescription medications - No Yes

If Yes, Please indicate:

Medication	Diagnosis	Dosage/ Frequency	When Taken	Comments

Surgical History No Yes

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. _____

Review of Systems

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

	No	Yes		No	Yes		No	Yes
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: _____

Occupation/ Leisure History

	No	Yes
Have you been exposed to chemical or xrays in work or hobby?	<input type="checkbox"/>	<input type="checkbox"/>
At work, are you exposed to high temperatures?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drive long distances?	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently use saunas or hot tubs?	<input type="checkbox"/>	<input type="checkbox"/>

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

- Alcohol – How many glasses per week do you usually drink? ___ Wine Beer Cocktails None
- Cigarettes – Number of packs / day ___ Number of years smoking ___ Year stopped Smoking _____ Never
- Recreational Drugs (Marijuana, Cocaine, etc.) Specify: _____ None
- Nutritional Supplements, herbs, etc. Specify: _____ None

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 YesDid 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:	No	Yes	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 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 HistoryHave you ever fathered a pregnancy? No Yes

Number conceived with current partner? _____

Number conceived with previous partners? _____

FERTILITY HISTORY**Pre-conceptual Health Screening**

Have you ever been tested for:	No	Yes	Date:	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 years have you had unprotected intercourse? _____ Additional Information: _____

How many 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? No Yes

Results: _____

Have you had semen analysis testing? No Yes

Date	Lab	Count	Motility	Morphology	Comments

Have you been evaluated for varicocele? yes no

Date	Physician	Findings

Have you had a Doppler study? (sonogram or ultrasound of the testicle?) no yesHave you had a varicocele repair? no yes If Yes, please explain: _____**- END -**