Fertility Specialists Medical Group, Inc.
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MALE PRE-CONSULT QUESTIONNAIRE

1. IDENTIFYING INFORMATION

Date this form is completed _____/_____/_____

Name ______________________________ DOB _____/_____/_____ Age __________

Significant Other Name ______________________________ DOB _____/_____/_____ Age __________

Primary Language spoken: English Spanish Other:____________________

Referred by: ______________________________ Primary Care MD ______________________________

How long have you been attempting conception? ___________ Number of years married/together ______________

Reasons you are coming to see us: ____

____

____

____

2. PREGNANCY HISTORY (that you have been responsible for) None

	Date	Mis-carriage?	Elective Abortion?	Months to conceive?	Infertility Treatment?	Weight and sex?	Complications?
1.							
2.							
3.							
4.							

3. OPERATIONS AND HOSPITALIZATIONS

	Date	Diagnosis	Operation	Where	Physician
1.					
2.					
3.					

4. MEDICATIONS *List all prescriptions and over-the-counter drugs used during the past year*

	Date	Dose and frequency	From when to when	Reason
1.				
2.				
3.				

5. ALLERGIES

	Drug or substance	Reaction
1.		
2.		

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6. OTHER HISTORY

Your occupation:...

Alcohol - type and number per week:……..

Cigarettes - packs smoked per day:...

Marijuana - amount: ....

Other drugs - type and amount: ....

Jacuzzi ❑ yes ❑ no IF yes, #/week: ....

Ever used intravenous drugs? ❑ yes ❑ no

Radiation exposure: ❑ yes ❑ no

7. MEDICAL ILLNESSES

Do you have or have you had?

- ❑ Cancer
- ❑ Diabetes
- ❑ Hypertension
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Mitral valve prolapse
- ❑ Heart murmur
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Hepatitis / liver disorder
- ❑ Gall bladder problems
- ❑ Ulcers
- ❑ Colitis / enteritis
- ❑ Kidney disorder
- ❑ Rubella
- ❑ Anesthetic complication
- ❑ Mumps
- ❑ Chicken pox
- ❑ Mononucleosis
- ❑ Serious injury / accident
- ❑ Blood transfusion
- ❑ Psychiatric disorder
- ❑ Seizures
- ❑ Stroke
- ❑ Blood clots
- ❑ Anemia
- ❑ Bleeding disorder
- ❑ Thyroid disorder
- ❑ Recent immunization

Please explain a "Yes" answer to any of the above____

____

____

8. SYSTEMIC REVIEW

Height ________ Weight ________ Maximum Weight___________ Minimum Weight_____________ Weight change in last 2 yrs__________

Have you had any significant dietary changes over the past 3 years?..

Have you participated in any vigorous exercise programs over the past 3 years?.....................................

If so please document : Vigorous exercise: type .... hrs/week ....

- The effect of being overweight on male fertility have been well documented.
- Please speak with your physician regarding weight loss attempts and ideal weight range for you height.
- Obesity does not usually cause infertility but obesity may have significant impact on treatment responses

Headaches: Number per week _________ Medication used ___________________________

- ❑ Wear glasses
- ❑ Wear contact lenses
- ❑ Sinus problems
- ❑ Hayfever
- ❑ Ringing in ears
- ❑ Hearing loss
- ❑ Denture / bridges
- ❑ Counseling
- ❑ Anemia
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Fainting spells
- ❑ Leg swelling
- ❑ Calf pain
- ❑ Cough
- ❑ Cough up blood
- ❑ Bladder/kidney infections
- ❑ Urgent / frequent / painful urination
- ❑ Blood / abnormal color of urine
- ❑ Unable to control urination
- ❑ Abnormal urinary tract
- ❑ Kidney x-ray
- ❑ Bladder cystoscopy
- ❑ Chronic constipation
- ❑ Varicose veins
- ❑ Easy bruising
- ❑ Prolonged bleeding
- ❑ Bleeding from gums
- ❑ Nosebleeds
- ❑ Take aspirin/ibuprofen frequently
- ❑ Chest x-ray / TB skin test
- ❑ Abdominal pain
- ❑ Nausea and vomiting
- ❑ Vomiting blood
- ❑ Ulcer
- ❑ Food intolerance
- ❑ Gallstones
- ❑ Jaundice / hepatitis
- ❑ Recent stress increase
- ❑ Diarrhea
- ❑ Blood in bowel movement
- ❑ Irritable bowel
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Abnormal liver test
- ❑ Wheezing
- ❑ Acne
- ❑ Skin disorder
- ❑ Rash
- ❑ Hives
- ❑ Skin cancer
- ❑ Recent anxiety increase
- ❑ Sensation loss / numbness
- ❑ Muscle control / weakness
- ❑ Heat or cold intolerance
- ❑ Damp skin
- ❑ Extraordinary fatigue
- ❑ Back pain
- ❑ Arthritis
- ❑ Unusual hair loss
- ❑ Shortness of breath

OTHER: ____

____

If yes, please comment: ____

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9. FAMILY HISTORY / GENETIC HISTORY

	Mother	Father	Brothers: #	Sisters: #	Children: #	Other
Cancer (type)						
Diabetes						
Hypertension						
High Cholesterol						
Heart Disease						
Stroke						
Mental Retardation						

Do you or anyone in either family have? *Information is used for genetic testing recommendation purposes*

- ❑ Neural tube defects/spina bifida/anencephaly
- ❑ Thalassemia
- ❑ Down syndrome
- ❑ Hydrocephalus
- ❑ Stillbirth
- ❑ 3 or more miscarriages
- ❑ Cystic fibrosis
- ❑ Muscular dystrophy
- ❑ Huntington chorea
- ❑ Mental retardation / fragileX
- ❑ Epilepsy or seizures
- ❑ Phenylketonuria
- ❑ Diabetes
- ❑ Tay-Sachs disease
- ❑ Sickle cell disease or trait
- ❑ Hemophilia
- ❑ Hormonal disorder
- ❑ Kidney disease
- ❑ Neurofibromatosis
- ❑ Any birth defects?
- ❑ Chromosomal disorder
- ❑ Genetic / inherited disorder
- ❑ Baby with birth defects
- ❑ Infertility
- ❑ Mental illness
- ❑ Myotonic dystrophy
- ❑ Any inherited disorders?

Please explain a "Yes" answer to any of the above____

____

10. GENETIC SCREENING:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and is the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on your ethnicity.

Are you: ❑ Caucasian ❑ Hispanic ❑ Asian ❑ African American ❑ Other (______________________)

Ashkenazi Jewish ❑ Yes ❑ No Mediterranean/Asian/French Canadian ❑ Yes ❑ No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

❑ Down syndrome ❑ Mental retardation / Fragile X ❑ Hormonal disorder Infertility

11. SEXUAL PRACTICES

MALE: ❑ Erectile Dysfunction ❑ Ejaculation Issues ❑ Yes ❑ No Medications:______________________

PARTNER:
- ❑ Any changes in Sexual Spontaneity ❑ Any changes in Sexual Desire
- ❑ Are you able to achieve an orgasm ❑ Yes ❑ No
- ❑ Frequency of Intercourse _____ Is this increased or decreased in past year
- ❑ Painful intercourse with penile entry ❑ Painful intercourse with deep thrusting
- ❑ Any changes in sexual desirability-image-attractivenss

12. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).

Have you been treated for infertility previously? ❑ YES ❑ NO If yes, who was your physician? …………………………..
What cause of infertility was diagnosed? ………………………………………………………………………………………

What medications have you taken for infertility? ……………………………………………..

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

❑ Semen Analysis When _____/_____/_____ Results ………………..……………………..

❑ Chromosomes When _____/_____/_____ Results ………………..……………………..

❑ Genetic screening When _____/_____/_____ Results ………………..……………………..

❑ OTHER____

Have your partner ever undergone Artificial Insemination (IUI) ❑ YES ❑ NO or In Vitro Fertilization (IVF)? ❑ YES ❑ NO
If yes, ❑ partner ❑ donor sperm #IUI's ____ #IVF cycles ______

We, at FSMG, understand that infertility can place a significant burden on the respective couple. This stress can have a profound impact on the reproductive system. Given these facts and our emphasis on treating the whole person, we would like to know your experience with / willingness to try alternative therapies. These include, but are not limited to:

- Acupuncture (if so, which acupuncturist)____
  Dates: + Current + Previous ____
- Herbal treatment____
  Dates: + Current + Previous ____
- Massage____
  Dates: + Current + Previous ____
- Psychological/group therapy____
  Dates: + Current + Previous ____
- Yoga / biofeedback / stress reduction techniques____
  Dates: + Current + Previous ____

Welcome, we look forward to working with you. Please write down any specific concerns you want to review at your visit.

-The FSMG Team