New Patient Questionnaire - Male

Name _____ DOB _____/_____/_____ Age _____

□ N/A Partner's Name _____ DOB _____/_____/_____ Age _____

Primary Language spoken: □ English □ Spanish □ Other _____

Date this form completed _____/_____/_____ Primary Care MD _____

Reason for consultation □ Infertility □ Recurrent Pregnancy Loss □ Use of egg donor and/or gestational carrier

□ Sperm Freezing/Banking □ _____

_____

Reproductive Goals (if applicable): Number of children desired? _____ Number of pregnancies desired? _____

Pregnancy History □ None (number of pregnancies in which you have been involved)

Date or Year	Time to conceive	Spontaneous/ IUI/IVF	Outcome (Delivery, Loss, Ectopic, Abortion)	Weight/Sex (if delivery)	Current ♀/ Different ♀/ Donor

Illnesses/Medical Conditions □ None **(include any recurrent reason you are seeing a physician)**

Diagnosis	Active?	Name of Physician Following

Operations and Hospitalizations □ None **(include any overnight stay in the hospital/anesthesia exposure/surgery)**

Date	Diagnosis	Operation	Hospital/Clinic	Physician

Medications □ None **(list prescriptions, over-the-counter medications, supplements used or using in the past year)**

Medication/Supplement	Dose and Frequency	Dates of Use	Reason for Use

Allergies ☐ None **(list all allergic reactions to medications and/or substances such as latex)**

Medication or Substance	Reaction

Medical Illnesses

Do you have or have you had?

☐ Mitral valve prolapse ☐ Heart disease ☐ Rheumatic fever ☐ Seizures
☐ Hypertension ☐ High cholesterol ☐ Stroke ☐ Thyroid disorder
☐ Asthma ☐ Pneumonia ☐ Heart murmur ☐ Gall bladder problems
☐ Diabetes ☐ Kidney disorder ☐ Colitis / enteritis ☐ Hepatitis
☐ Rubella ☐ Tuberculosis ☐ Chicken pox ☐ Psychiatric disorder
☐ Blood clots ☐ Anemia ☐ Bleeding disorder ☐ Blood transfusion
☐ Recent immunization ☐ Cancer ☐ Serious injury / accident

Please explain a "Yes" answer: _____

_____

Other History

Occupation _____ Radiation exposure? ☐ no ☐ yes _____

Cigarettes ☐ In past ☐ Current packs/day_____ Marijuana ☐ no ☐ yes, frequency _____

Caffeinated drinks/day _____ Recreational Drugs (type/freq):_____

Alcohol ☐ no ☐ yes , #/week _____

Review of Systems

Height _____ Weight _____ Maximum Weight_____ Minimum Weight_____ Weight change in last 2 yrs_____

Do/have you participated in any significant dietary changes over the past 3 years? _____

Vigorous exercise Type _____ hrs/week _____

Do you have or have you had?

Heart/Lungs
☐ Sinus problems
☐ Wheezing
☐ Shortness of breath
☐ Persistent Cough
☐ Coughing up blood
☐ Chest pain
☐ Irregular heart beat

GI
☐ Abdominal pain
☐ Nausea/vomiting
☐ Chronic constipation
☐ Diarrhea
☐ Bloody stools
☐ Hemorrhoids
☐ Irritable bowel syndrome
☐ Vomiting blood
☐ Hernia
☐ Jaundice / hepatitis
☐ Gluten Sensitivity
☐ Abnormal liver test

Urinary
☐ Urgency
☐ Frequency
☐ Painful urination
☐ Bloody urine

Skin
☐ Acne
☐ Chronic Rash
☐ Skin cancer
☐ Unusual hair loss

Mental Health
☐ Anxiety
☐ Stress
☐ Counseling

Other
☐ Back pain
☐ Muscle weakness
☐ Sensation loss/numbness
☐ Leg swelling
☐ Calf pain

Other medical concerns _____

_____

_____

Family/Genetic History ☐ Adopted ☐ Adopted and unaware of family/genetic history

	Mother	Father	Brothers: #	Sisters: #
Cancer (type)				
Heart Disease				
Stroke				
Uterine fibroids				
Intellectual Disability				
Endometriosis				
Early Menopause				

Do you or anyone in either family have? Information is used for purpose of making genetic testing and health screening recommendations.

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

Please explain a "Yes" answer to any of the above: _____

_____

Genetic Screening

Have you had any genetic screening or testing? ☐ No ☐ Yes _____

It is recommended that **all couples/individuals** attempting conception be offered at a minimum cystic fibrosis screening. Additional testing may be recommended based on ethnicity and/or race. Genetic screening can be performed for a specific disease or in panels that look at a wide range of inherited disorders. Please ask your physician if you are interested in genetic screening.

Are you: ☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American

☐ Ashkenazi Jewish ☐ Sephardic Jewish ☐ Mediterranean/French Canadian

☐ Other_____

Sexual Practices

Sexually active ☐ Yes ☐ No

Do you have erectile dysfunction? ☐ No ☐ Yes If yes, how often? _____

Do you have ejaculatory dysfunction? ☐ No ☐ Yes If yes, how often? _____

Comments/Concerns _____

_____

_____

History of Evaluation/Treatment for Fertility or Recurrent Pregnancy Loss ☐ N/A

Have you previously been evaluated for infertility? ☐ No ☐ Yes If so who was your physician? _____

Were any of the following tests performed?

☐ Semen Analysis _____/_____/_____ Results _____

☐ Semen Analysis _____/_____/_____ Results _____

☐ Surgery _____/_____/_____ Results _____

☐ Chromosomes _____/_____/_____ Results _____

☐ Blood tests _____/_____/_____ Results _____

Other _____

Were any of the following diagnosed? ☐ Oligospermia ☐ Azoospermia ☐ Low motility

☐ Abnormal/poor morphology ☐ Hormonal issues ☐ Chromosomal abnormality

☐ _____

What medications have you taken for infertility? Please check all that apply:

☐ Clomid ☐ hCG ☐ Supplements/vitamins

Other _____

Have you participated in any of the following treatments? (IUI = intra-uterine or artificial insemination)

Natural Cycle - IUI ☐ No ☐ Yes

Clomid/Letrozole (partner) – IUI ☐ No ☐ Yes

Gonadotropin (partner) – IUI ☐ No ☐ Yes

IVF ☐ No ☐ Yes # Cycles _____

Do you have sperm cryopreserved at another location? ☐ No ☐ Yes Clinic/Bank _____

Do you have cryopreserved embryos at another location? ☐ No ☐ Yes Clinic/Bank _____

Have you had/used any of the following complimentary therapies?

Acupuncture ☐ No ☐ Yes Practitioner _____ ☐ ongoing ☐ discontinued

Herbs/Teas ☐ No ☐ Yes Name(s) _____ ☐ ongoing ☐ discontinued

Yoga ☐ No ☐ Yes ☐ ongoing ☐ discontinued

Therapy ☐ No ☐ Yes ☐ ongoing ☐ discontinued

Is there anything else you would like us to know? _____

_____

_____

_____

_____

_____