www.urologyinfo.org

Male Infertility Questionnaire

UROLOGY INFO

Date:

Name:

Age:

Occupation:

Phone Number:

Physician Name:

Referring Physician Name:

Referring Physician Phone Number:

Allergy to any medications:

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Any other allergies:

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UROLOGY INFO

The following questionnaire is designed to help us evaluate your infertility. Please choose or fill in the appropriate answer.

Section 1- Important Numbers:

How long have you been trying to achieve a pregnancy? ……

How long have you not used contraception? ……..

How often are you having sex (times per week)? ……

When was the onset of your puberty? ……

Section 2 – General Information:

Are you currently married?	Yes	No
Has your female partner ever been pregnant before?	Yes	No
Is your female partner being seen by a fertility specialist?	Yes	No
If so, was the evaluation normal?	YES	No
Have you previously conceived with your current partner?	Yes	No
If yes, did you have any difficulties in initiating?	Yes	No
Have you previously conceived with another woman?	Yes	No
If yes, did you have any difficulties in initiating?	Yes	No
Have you ever been evaluated for infertility before?	Yes	No
Have you been previously treated for infertility?	Yes	No
If yes, was it successful?	Yes	No
Have you had a semen analysis?	Yes	No
Were the results of the semen analysis normal?	Yes	No

UROLOGY INFO

Section 3- Sexual History

Do you have a low sex drive or low desire for sex?	Yes	No
Do you have any difficulty achieving or maintaining an erection?	Yes	No
Do you ejaculate during intercourse?	Yes	No
Do you ever use lubricants during sex?	Yes	No
Does your urine ever look cloudy after sex?	Yes	No
Are you timing intercourse with your wife ovulation?	Yes	No

Notice: Name type of lubricant you use during sex if you use one. ……..

Section 4- Related Genitourinary History

Have you been diagnosed with small or soft testes?	Yes	No
Do you have or have you ever had an undescended testicle?	Yes	No
Have you ever had testicular torsion (twisting of the testicle)?	Yes	No
Have you had previous injury to your testicles or penis requiring hospitalization or surgery?	Yes	No
Have you had swelling in your scrotum or testes?	Yes	No
Have you ever had prolong pain in your scrotum or testes?		
Did you have the mumps after puberty?	Yes	No
Have you had infection of epididymis (Epididymitis)?	Yes	No
Are there any lumps or bumps in your testes?	Yes	No
Have you ever diagnosed with testicular cancer, lymphoma or leukemia?	Yes	No
Have you ever had prostate infection (prostatitis)?	Yes	No
Have you ever had any sexual transmitted diseases?	Yes	No
Have you experienced any penile discharge?	Yes	No

UROLOGY INFO

Notice: Choose type of sexually transmitted disease if you had one:

Chlamydia Gonorrhoea Syphilis Herpes HIV

Section 5- Other Important Urologic Problems:

Do you have flank, suprapubic or perineal Pain?	Yes	No
Have you ever had urinary tract infection?	Yes	No
Do you have burning when you urinate?	Yes	No
Do you have frequent urination during the daytime hours?	Yes	No
Do you wake up frequently from sleep because you had to urinate?	Yes	No
Do you have sudden urge to urinate with little or no warning?	Yes	No
Do you sometimes have to push or strain to urinate?	Yes	No
Have you ever had blood in your urine?	Yes	No
Have you ever been diagnosed with prostate cancer?	Yes	No
Have you ever been diagnosed with bladder cancer?	Yes	No
Have you ever been diagnosed with penile cancer?	Yes	No
Have you ever been diagnosed with benign prostatic hyperplasia?	Yes	No
Have you ever had urethral stricture?	Yes	No

Notice – Your last PSA value level if you are > 40-50: ……..

Notice- Do you have History of any other urologic diseases?

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Section 6 - Endocrine History

Do you have diabetes?	Yes	No
Do you have a known thyroid problem?	Yes	No
Have you had any heat or cold intolerance or any excess hair growth?	Yes	No
Have you had any discharge or tenderness in your breasts?	Yes	No
Do you have difficulty with your peripheral vision?	Yes	No
Do you have a poor sense of smell?	Yes	No

Section7-Related systemic, respiratory, kidney, liver and nervous system problems

Have you had any severe illness, surgeries, fevers, and severe weigh loss in the last 3-6 months?	Yes	No
Do you feel fatigued?	Yes	No
Have you had any unintentional weight loss?	Yes	No
Have you ever had any cancer?	Yes	No
Do you have kidney failure?	Yes	No
Do you have liver cirrhosis?	Yes	No
Do you have any sinus problem?	Yes	No
Do you have a cough you cannot get rid of?	Yes	No
Have you ever had tuberculosis?	Yes	No
Do you have multiple sclerosis (MS)?	Yes	No
Do you have any other known nervous system problems?	Yes	No
Do you have any spinal cord problems?	Yes	No

UROLOGY INFO

Section 8-Genetic History

Have you been diagnosed with cystic fibrosis?	Yes	No
Have you been diagnosed with Klinefelters?	Yes	No
Have you been diagnosed with Y chromosome microdeletions?	Yes	No
Have any of your blood relatives had issues with infertility or required assisted reproductive techniques?	Yes	No
Have any of your blood relatives been diagnosed with cystic fibrosis?	Yes	No

Notice:

What was the result of you karyotype if you had one?

……

Notice:

What was the result of chromosome Y microdeletion test if you had one?

……..

Notice:

What was the result of your CF gene test if you had one?

……..

Notice:

What was the result of your Genetic Counselling if you had one?

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UROLOGY INFO

Section 9- Past Surgical history:

Have you had bladder neck surgery?	Yes	No
Have you had bladder surgeries?	Yes	No
Have you had prostate surgeries?	Yes	No
Have you had any surgeries because of urethral stricture?	Yes	No
Did you undergo any bladder or penis surgery as a child?	Yes	No
Have you ever had surgery to fix a hernia as a child or as an adult?	Yes	No
Have you had surgery for a varicocele?	Yes	No
Have you had a vasectomy?	Yes	No
Have you had a vasectomy reversal?	Yes	No
Have you had hydrocelectomy or spermatocele suregery?	Yes	No
Have you had testes biopsy?	Yes	No
Have you ever had any other abdominal surgery?	Yes	No
Have you ever had brain surgeries?	Yes	No

Notice:

Have you ever had other surgeries?

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UROLOGY INFO

Section 10- Drug history

Have you ever taken body building drugs, anabolic steroid supplements, testosterone or DHEA?	Yes	No
Have you ever taken corticosteroids like prednisone, cortisone?	Yes	No
Do you take cimetidine?	Yes	No
Do you take sulfasalazine?	Yes	No
Do you take nitrofurantoin?	Yes	No
Do you take nifedipine?	Yes	No
Do you take Tamsulosin (Flomax, Omnic) , Doxazosin (Cardura) or Terazosin (Hytrin)?	Yes	No
Do you take ketoconazole?	Yes	No
Do you take antidepressants?	Yes	No
Do you take Antipsychotics?	Yes	No

Notice: Have ever taken antioxidant pills to improve your fertility? Write its name.

……

Notice: If you have had retrograde ejaculation and have taken a medication for that, choose its name in the list below:

Ephedrine sulphate Midodrine Brompheniramine maleate
Imipramine Desipramine

Notice: Have you received hormonal injection? Yes No

If you have had one, choose its name in the list below:

HCG injection FSH injection

Notice- List any other drugs that you are taking for your urological problems?

1-…… 2……

UROLOGY INFO

Section 11- Radiation, chemotherapy or toxic materials:

Have you been exposed to toxic chemicals or pesticides?	Yes	No
Have you been exposed to radiation?	Yes	No
Have you ever received chemotherapy?	Yes	No

Section 12- Habits

Do you use hot tubs or saunas regularly?	Yes	No
When using a laptop computer, do you rest it on your lap?	Yes	No
Do you smoke tobacco?	Yes	No
Are you a former smoker?	Yes	No
Do you use any of the following currently? marijuana cocaine heroin methadone	Yes	No
Do you use alcohol on a regular basis?	Yes	No

Section 13 – Sperm retrieval History

Answer this part only if you have been treated by an infertility facility before

Infertility facilities need your sperms for a variety of therapeutic modalities. We need to know how your sperms were collected at that time. Choose the appropriate answer in table below:

I personally collect my semen into a glass or plastic cup for therapeutic purposes	Yes	No
My sperms were retrieved in the laboratory from my urine for therapeutic purposes	Yes	No
I had MESA	Yes	No
I had PESA	Yes	No
I had TESE	Yes	No
I had vibrostimulation	Yes	No
I had electroejaculation	Yes	No

Section 14 – Infertility treatment Modalities

Answer this part only if you have been treated by an infertility facility before

We need to know what you did after you had your sperms retrieved. Choose the appropriate answer in table below:

They Cryopreserved them	Yes	No
They were used for IUA	Yes	No
They were used for IVF	Yes	No
They were used for ICCI	Yes	No

Section 15- Semen analysis

How many days of abstinence did you have before collecting your semen?

……

Please write the values of your last 2 semen analysis in table below:

Date: ……

Parameter	Your test value	Lower normal limit
Semen volume (mL)		1.5
Total sperm count (10^6)		39
Sperm count per milliliter (10^6 /mL)		15
Total sperm motility (%)		40
Progressive motility (%)		32
Vitality (%)		58
Normal sperm morphology (%)		4
PH		>7.2
Peroxidase-positive leukocytes (10^6/mL)		<1.0

Date: ……..

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UROLOGY INFO

Notice:

Please bring the following items, if you have done them, when you come to see us:

1- Last 2 semen analyses
2- Sonograms
3- Transrectal sonogram
4- Hormonal tests
5- Post-ejaculate urine analysis
6- Semen culture
7- Other relevant tests