JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

4007357500-550

MALE FERTILITY QUESTIONNAIRE

Addressograph

2Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Patient Name: _____

Date of Birth: _____ Date of first visit: _____

Partner's Name: _____

Date of Birth: _____

Gynecologist: _____ Reproductive Endocrinologist: _____

1.	How long have you and your partner been trying to conceive with unprotected intercourse? _____ Years _____ Months		
2.	Have you ever had a pregnancy with your current partner? If yes, how many pregnancies?_____ How many went to term?	yes	no
3.	Have you ever had a pregnancy with another partner? If yes, how many pregnancies?_____ How many went to term?	yes	no
4.	If you have children, how many boys and how many girls, and how old are they? _____		
5.	Has your current partner ever been pregnant with another partner? If yes, how many pregnancies?_____ How many went to term?	yes	no
6.	Have you ever taken Clomid / clomiphene? If yes, when and for how long? _____	yes	no
7.	Have you had or tried any other types of fertility treatments? IUI? IVF? ICSI? If yes, explain briefly:_____	yes	no
8.	Have you ever had a varicocele repair?	yes	no
9.	Have you ever been treated for a sexually transmitted infection? If yes, what infection? _____ When? _____	yes	no
10.	Have you ever been diagnosed with tuberculosis? If yes, when? _____	yes	no
11.	At work, are you exposed to chemicals or pesticides? If yes, what chemicals?_____	yes	no
12.	Have you ever been exposed to a large amount of radiation, or exposed for a long time?	yes	no
13.	Have you ever had chemotherapy? If so, please list what medications you received, if you know them: _____ When did you receive and finish treatment? _____	yes	no
14.	Have you had a recent (within the past year) infection with a fever? If yes, how long ago? _____ How high? _____	yes	no
15.	Do you take hot baths, saunas, or whirlpools? If yes, how often? _____ When was the last time? _____	yes	no
16.	Did you have mumps when you were a child? If so, did it affect your testes? _____ Which side(s)? _____	yes	no
17.	When you were a child, did your testes have to be surgically brought into scrotum? If yes, which side(s)? _____ How old were you? _____	yes	no
18.	When you were a child, did your testes ever twist, requiring surgery? If yes, which side(s)? _____ Were either testes removed? _____ (which side?) How old were you? _____	yes	no

Please see reverse side.

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19.	Have you ever had a hernia operation? If yes, which side(s) and when: _____	yes	no
20.	Did you ever have a bladder operation? If yes, what was done and when? _____	yes	no
21.	Did you ever have major trauma or other surgery of your testes? If yes, what side(s)? (right / left / both). When? _____	yes	no
22.	Have you ever had any surgery besides those mentioned above? If so, what and when? _____	yes	no
23.	How old were you when puberty started?_____		
24.	How often do you have any sexual activity?_____		
25.	How often do you have intercourse?_____		
26.	Do you use lubricant(s) during intercourse? If so, what type/brand?_____	yes	no
27.	Have you had any problems with erections?	yes	no
28.	Do you have diabetes?	yes	no
29.	Do you have high blood pressure or abnormal cholesterol? If yes, which of these: _____	yes	no
30.	Besides diabetes and high blood pressure, have you had or do you have any major medical illness(es)? If yes, what illness(es)? _____	yes	no
31.	Are you currently taking any medications on a regular basis? If yes, what medications? _____	yes	no
32.	Are you allergic to any medications? If yes, what medications?_____	yes	no
33.	Have any blood relatives had difficulty to conceive children? If yes, which relatives (eq. Mother's uncle, etc.):_____	yes	no
34.	Do any blood relatives have cystic fibrosis?	yes	no
35.	Do / did you smoke cigarettes? If yes, how many packs a day? _____ For how long? _____ If you quit, when did you quit? _____	yes	no
36.	Have you ever used marijuana? If so, how often and how recently? _____	yes	no
37.	Have you ever used any other recreational drugs? If so, which drugs, how often, and how recently? _____	yes	no
38.	Have you ever used anabolic steroids or body-building drugs? If yes, which drugs? _____ For how long, and how recently? _____	yes	no
39.	Do you drink alcoholic beverages? If yes, how many drinks (beers, glasses of wine, tumblers, etc.) a week? _____	yes	no
40.	Has your current partner been diagnosed with an obstruction of her tubes?	yes	no
41.	Does your current partner have (or had) endometriosis?	yes	no
42.	Has your current partner ever has a serious gynecological infection?	yes	no
43.	Had your current partner needed medication to stimulate her ovaries?	yes	no
44.	Does your current partner have irregular menstrual cycles?	yes	no
45.	Anything else you'd like to discuss / address today? If so, what?_____	yes	no

Completed by Patient Signature _____ Printed Name _____ Date _____ Time _____

Reviewed by Signature _____ Credentials _____ Printed Name _____ Date _____ Time _____