Southwest Urologic Specialists, PC
875 N. Greenfield Road, Suite 105 Gilbert, Arizona 85234
Tel: 480.897.2727 Fax: 480.892.3035

FERTILITY QUESTIONNAIRE **DATE ________________________**

Please answer these questions and bring the completed questionnaire with you to your appointment.

RELATIONS
How long have you been married? ___________________

How long have you been having sexual relations with contraception? ____________________________

How long have you been having sexual relations WITHOUT contraception? ______________________

What form of contraception did you use? Condoms, withdrawal, rhythm, birth control pills (Please circle all that apply.)

When did you stop using birth control? ________________

When did you start actively trying to conceive? ____________________

Did any of your partners, including your current partner, become pregnant from you? YES NO
If YES, are there any living children? YES NO

If with a former partner(s), was there any trouble impregnating her (them)? YES NO

If NO, was this by choice or by lack of ability on either one's part? (Please circle one by choice, by ability)

If with your current partner, are there any living children, and if so, what are their ages? YES NO
____

If there are no living children, were they lost by abortion (induced or spontaneous), at birth or after birth (trauma or illness)? Please describe.
____

UROLOGICAL HISTORY
To the best of your recollection, were your testicles descended at birth, came down later in life, or were they brought down surgically? (Please circle one.)

Has any one ever told you that you have a hydrocele or a varicocele? YES NO If YES, please circle which.

Do you have any history of urological infections such as urine, prostate, testicular, venereal? YES NO (gonorrhea, syphilis, chlamydia, venereal warts) If YES, please circle which.

If YES, were you treated and if so with what?

Do you have any other urologic problems (e.g. trouble urinating, blood in your urine, kidney stones, any urologic cancer, any history of sexually transmitted diseases)? YES NO
If YES, please describe.____
____

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PAST HISTORY

A. MEDICAL HISTORY
Do you have any medical illness or conditions? (e.g. diabetes, hypertension, sickle cell, etc.)
YES NO If YES, please list.

____

____

B. SURGICAL HISTORY
Have you had any operations? (e.g. tonsillectomy, appendectomy, hernia repair, abdominal surgery) YES NO If YES, please list the operations and their dates.

____

____

C. ALLERGIES
Are you allergic to any medications?
YES NO If YES, please list which ones and what your reaction was.

____

____

____

D. MEDICATIONS
Have you taken any medications in the past year?
YES NO If YES, please list all, including dose and frequency (including Aspirin, Tylenol, decongestants, sleeping pills, vitamins, etc.).

____

____

REVIEW OF SYSTEMS

A. Do you have any other medical problems?
YES NO If YES, please explain.

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____

____

B. Have you ever received radiation, x-ray, or cobalt treatment?
YES NO Please do not include x-rays for diagnostic purposes. If YES, please state why, date, and number of treatments.

____

____

C. Have you ever had a serious injury or accident resulting in permanent damage?
YES NO If YES, please describe.

____

____

PSYCHOLOGICAL

A. Have you found that sexual relations have become a job instead of an adventure?
YES NO If YES, have you ever seen a psychiatrist or a psychologist? YES NO
If YES, please describe the date(s), and how and if it has helped.

____

____

B. Do you have any important personal problems or stress that may be interfering with your ability to conceive?
YES NO If YES, please describe.
____
____

C. Would you describe yourself as being an anxious or depressed person?
YES NO If YES, please circle one and please describe in what way.
____
____

D. Are you having fights with your wife (or sexual partner) on a regular basis?
YES NO If YES, about what?
____
____

E. If YES, do you or have you seen a therapist? YES NO

SOCIAL HISTORY

A. TOBACCO
Do you or did you ever smoke? YES NO
If yes, please answer the following:
How many pack(s) per day do you or did you smoke? ____________________
For how many years do you or did you smoke? __________________________
If you stopped, how long ago did you stop? _____________________________

B. ALCOHOL (Beer, wine, liquor, etc.)
Do you drink? YES NO If YES, please indicate the type and amount.
Beer _______bottles/weekday _______days/workweek Amount weekend ___________
Wine _______glasses/weekday _______days/workweek Amount weekend ___________
Liquor _______ounces/weekday _______days/workweek Amount weekend ___________
If you do not drink now, but have in the past, when and how much did you drink?
____

C. What kind of work do or did you do? _________________________
If you are retired, when and why did you retire? _____________________________________

RECREATIONAL DRUGS
Do you or did you ever use recreational drugs? YES NO
If YES, list type and amount used. Please circle one.
NOW IN THE PAST
Type _________________________________per day ____________per week____________________
Type__________________________________per day ____________per week____________________

MARITAL & SEXUAL HISTORY
How often do you have coitus?______________per week, _________________per month.

Do you feel that you have a good marriage? YES NO

Do you need to use any lubricant? YES NO
If YES, which lubricant do you use? Please circle or fill in. KY, Surgilube, Vaseline ______________

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Do you know when your wife has a greater chance of being fertile (when she ovulates)?
YES NO
If YES, do you increase the number of times you have sex during those times?
YES NO

Do you practice the laws of Mikveh (a religious custom of many Jews)?
YES NO

PREVIOUS FERTILITY EXAM AND OR TREATMENT (HUSBAND)
Have you ever been seen by any other doctor(s) for sub fertility? YES NO
If YES, please write down the doctor's name and describe what kind of evaluation and or treatment you received if any.

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____
____

Did you have any semen analysis, and if so what were you told they showed?

____
____

PREVIOUS FERTILITY EXAM AND OR TREATMENT (WIFE)
Have you ever been seen by any other doctor(s) for sub fertility? YES NO
If YES, please write down the doctor's name and describe what kind of evaluation and or treatment you received if any. (e.g. blood tests, tests re ovulation and regularity, x-rays such as hystero salpinogram, endometrial biopsies, ectopic pregnancies, endometriosis, laparoscopy with or without laser surgery, etc.)

____
____
____

Did you have any post coital tests, and if so what were you told they showed?

____
____

How long are your (her) menses and are they regular?

____
____

FAMILY HISTORY
Is there any family history of any medical problems: cancer, diabetes, hypertension, heart disease, etc.
YES NO

____

PATIENT'S COMMENTS
Please list any comments you wish to make in addition to the above.

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____
____
____
____
____