Southwest Fertility Center
3125 N 32nd Street, Suite 200
Phoenix, AZ 85018

Sujatha Gunnala, M.D.
Phone (602) 956-7481
Fax(602)956-7591

Male Questionnaire

MALE PATIENT HISTORY

I. IDENTIFYING INFORMATION

Date _____
Name _____ Partner's Name _____
Address _____
Telephone Number – Day: ( ) _____ Evening: ( ) _____
Date of Birth _____ Partner's Date of Birth _____
Insurance Company _____

II. TRAVEL//WORK AND GENERAL BACKGROUND

All present employment – title(s), location, brief description, number of years employed:

Title	Location	Duties	Number Years
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

€ Heat € Toxic Fumes € Other Specify _____
€ Chemicals € Nuclear Radiation _____

III. MEDICAL HISTORY

Weight _____ Height _____ Blood Type (if known) _____

	Yes	No
Have you lost greater than 20 pounds of weight in the last year?	€	€
Do you follow a particular food diet or have any special dietary habits?	€	€

If yes, specify: _____

List the forms and frequency of regular vigorous exercise (swimming, cycling, running) and the age you began:

Exercise: _____ Hrs/Week _____ Age _____ Exercise: _____ Hrs/Week _____ Age ____

Do you frequently take saunas or steam baths?	€	€
Have you ever had surgery in the pelvic area?	€	€

If yes, specify: _____

Have you ever received X-rays in the pelvic are for therapy or diagnosis?	€	€

If yes, explain: _____

Do you have or have you ever had (check all that apply):

€ Anemia
€ Appendicitis
€ Arthritis
€ Blood Transfusion
€ Breast Milky Discharge
€ Breast Soreness
€ Breast Tenderness
€ Cancer? _____
_____
€ Chlamydia
€ Chronic Bronchitis
€ Chronic Headaches
€ Colitis
€ Cystic Fibrosis
€ Diabetes
€ Dizziness
€ Epilepsy
€ Gallbladder Problems
€ Gonorrhea
€ Heart Disease
€ Hepatitis
€ Herpes
€ High Blood Pressure
€ Kidney Infection
€ Liver Problem
€ Loss of Balance
€ Measles: German
€ Measles: Regular
€ Mumps
€ Mumps with Testes Involved
€ Neurological Problems
€ Nongonococcal Urethritis
€ Parasitic Infection
€ Pneumonia
€ Prostatitis
€ Rheumatic Fever
€ Scarlet Fever
€ Seizures
€ Syphilis
€ Testes Infection
€ Testes Injury
€ Testes Tumor
€ Thyroid Problems
€ Tuberculosis
€ Ulcers
€ Visual Disturbances
€ Any Allergies? List _____
€ _____

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	Yes	No
Have you ever been treated for cancer?	€	€
If yes, explain therapy: _____		
Within the last year, have you taken any prescription medication?	€	€
If yes, list all prescriptions and problems for which you were taking them: _____		
_____		
Are you taking any over-the-counter medication on a regular basis?	€	€
If yes, list all medications and diagnoses: _____		
_____		
Have you had a high fever (over 102°F) during the past 3-4 months?	€	€

Do you use or have you ever used (check all that apply):

€ Alcohol – How many glasses per week do you usually drink? Wine ____ Beer ____ Cocktails _____

€ Cigarettes – Number of packs per day _____

€ Illicit or Recreational Drugs (Marijuana, Cocaine, etc) If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify: _____

_____

IV. SEXUAL HISTORY	Yes	No
Are you circumcised?	€	€
When you were a child, were both testes descended into the scrotum?	€	€
At what age did you begin shaving regularly or start to grow a beard?	€	€
How many times have you been married? _____		
Have you ever produced a child with another partner?	€	€
If yes, how long did it take to produce a child? _____ When was this (dates)? _____		
Have you ever *tried* produced a child with another partner?	€	€
Do you have trouble getting an erection?	€	€
Maintaining an erection?	€	€
Do you have trouble with ejaculations?	€	€
If yes, € Premature ejaculations € Retrograde ejaculations?		
Do you feel that some of your ejaculate is deposited in the vagina?	€	€
Do you ever have orgasms without ejaculation during masturbation?	€	€
Do you have discharge from the penis?	€	€
How many times per week do you and your partner now have interource?	€	€
How many times do you have intercourse around ovulation?	€	€
Have you noticed a change in your sexual drive recently?	€	€

V. FAMILY HISTORY	Yes	No
Is there a family history of infertility?	€	€
If yes, who (list all members and relationship to you): _____		
_____		
Is there a history of hormonal disorders in your family?	€	€
If yes, who (relationship to you) and what type: _____		
_____		

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VI. HISTORY OF FERTILITY THERAPY

	Yes	No
Have you been treated for infertility before?	€	€
If yes, who was your physician? _____		
What cause of infertility was diagnosed? _____		

What drugs have you taken for infertility? Check all that apply:

€ clomiphene citrae (Serophene® Clomid®
€ hMG (Pergonal®,Menopur®)
€ tamoxifen
€ testolactone
€ bromocriptine (Parlodel®)
€ testosterone or Male Hormone
€ hCG (Profasi®, A.P.L®
€ fluoxymesterone(Halotestin®)
€ GnRH or LHRH (Factrel®)
€ urofollitropin or FSH (Metrodin®)
€ Other – Specify _____
€ None

	Yes	No
Have you ever had varicocele repair?	€	€
If yes, when? _____		
Have you ever had vasectomy reversal or repair?	€	€
If yes, when? _____		
Have you and your partner ever tried artifical insemination?	€	€
If yes, using € your sperm? € donor sperm?		
Have you and your partner ever tried in vitro fertilization?	€	€
If yes, when and explain: _____		

Which of the following test have you had performed? Check all that apply and the results if known:

€ Semen Analysis	When?_____	Results: _____
€ Chlamydia Test	When?_____	Results: _____
€ Mycoplasma Test	When?_____	Results: _____
€ Antibody Test	When?_____	Results: _____
€ Hamster Egg Test	When?_____	Results: _____
€ Chromosome Test	When?_____	Results: _____
€ Testicular Biopsy	When?_____	Results: _____
€ X-Ray or Ultrasound of Testes	When?_____	Results: _____
€ Hormonal Tests(FSH, LH, prolactin, testosterone)	When?_____	Results: _____
€ Thyroid Tests	When?_____	Results: _____
€ Other – Specify _____	When?_____	Results: _____

	Yes	No
Is your partner currently seeing a doctor for evaluation of infertility?	€	€
If yes, specify physician name and location: _____		
Does the doctor feel that your partner has an infertility problem?	€	€
If yes, what is the diagnosis and how is she being treated? _____		
_____		
Has she ever had children with another man?	€	€
If yes, when? _____		

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FOR PHYSICIAN USE ONLY

VII. PHYSICAL FINDINGS

_____

_____

_____

_____

_____

VIII. SURGERY

_____

_____

_____

_____

_____

IX. OTHER COMMENTS

_____

_____

_____

_____

_____

X. COURSE OF ACTION

_____

_____

_____

_____

_____