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MALE FERTILITY QUESTIONNAIRE

Name _____ Age_____ Date _____

Partner's name _____ Age _____

Have you been given a diagnosis related to fertility? If so, what diagnosis?

_____

How long have you and your partner been trying to get pregnant? _____

Have you tried any fertility treatments? If yes please answer the following:

Treatment type	Result	Dr. or Clinic name	Date

LAB TESTING

Have you had a sperm analysis?	**Y**	**N**

Results:

Count	
Motility	
Morphology	
DNA sperm fragmentation	

Name: _____ Date of Birth: _____

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FERTILITY HISTORY

Have you had children previously? If so, how many: _____ Children's ages: _____ How long it took to conceive: _____	**Y**	**N**
Do you ride a bicycle regularly?	**Y**	**N**
Do you take a hot tub/sauna/hot bath regularly?	**Y**	**N**
Do you wear tight pants regularly?	**Y**	**N**
Have you had any hormone replacement therapy? If yes, what kind and when?	**Y**	**N**

UROGENITAL HISTORY

Do you have a history of any varicocele (enlarged veins inside scrotum)?	**Y**	**N**
Have you ever had undescended testes?	**Y**	**N**
Have you had any urogenital surgeries? If yes, explain: _____ Date: _____	**Y**	**N**
Have you ever had any trouble maintaining an erection? If yes, did the problem exist with self stimulation? Y / N	**Y**	**N**
Have you ever experienced premature ejaculation?	**Y**	**N**
Do you experience a morning erection?	**Y**	**N**
Do you experience nocturnal emissions regularly?	**Y**	**N**
Have you ever experienced any issues with low libido? If yes, please explain	**Y**	**N**
Have you ever experienced abnormal discharge from your penis?	**Y**	**N**
Have you been exposed to any environmental toxins? If yes, what kind?	**Y**	**N**

Anything else you want us to know?_____

_____

_____

Name: _____ Date of Birth: _____