UROLOGY ASSOCIATES
595 SHREWSBURY AVE
SHREWSBURY, NJ 07702

Your Name_____

Your Wife/Partner's Name_____ and AGE: _____

DEAR PATIENT:

If your office visit is for an infertility evaluation it would be most helpful if you would complete this form to streamline your upcoming office visit. We know that everyone hates forms but by furnishing this information you will allow us the best opportunity to help you with your fertility issues. Please answer the questions to the best of your ability – use the check boxes where appropriate. If the answer is ☑**NO** then you can move right on to the next question, if the answer is ☑**YES** then please provide further details in the appropriate sections.

ALSO: We would like you to bring in a semen specimen so we can perform a semen analysis in our office.

- Please try to obtain the specimen after at least 2 days of abstinence.
- Please try to collect the entire specimen for the most accurate results.
- Please DO NOT use a condom for collection since condoms contain materials that can destroy the motility of the sperm.
- Please try to obtain the specimen so that it will be within 2 hours of your office visit.
- Any small clean glass or plastic container can be used for collection - alternatively, you can obtain a sterile specimen cup from your pharmacy or on Amazon.
- Please try to keep the specimen at body temperature during transport to our office.

INFERTILITY HISTORY:

1. How many months have you and your partner been trying to conceive with unprotected intercourse?
   # MONTHS _____

2. Have you ever had a pregnancy with your current partner? ☐NO ☐YES
   If YES→how many? _____
   How many went to term? _____
   What are ages & sex of children _____

3. Have you ever had a pregnancy with another partner? ☐NO ☐YES
   If YES→how many? _____
   How many went to term? _____
   What are ages & sex of children _____

4. Has your current partner ever been pregnant with another partner? ☐NO ☐YES
   If YES→how many? _____
   How many went to term? _____
   What are ages & sex of children _____

5. Have you ever taken the prescription drug Clomid? ☐NO ☐YES
   If YES →when & how long? _____

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6. Have you had any other types of fertility treatments? ☐NO ☐YES
If YES →please explain briefly: _____

7. Have you ever had a sperm count(s) done? ☐NO ☐YES
If YES →what were the results as you understood them: _____

8. Have you had bloodwork done to check your hormone levels? ☐NO ☐YES
If YES →what were the results as you understood them: _____

MEDICAL HISTORY:

9. Have you had a recent infection (within 6 months) with a fever? ☐NO ☐YES
If YES →How high was your temperature_____

10. Did you have mumps as a child? ☐NO ☐YES
IF YES →did it affect your testicles? ☐NO ☐YES

11. Have you ever been treated for a sexually transmitted disease? ☐NO ☐YES
If YES → ☐ Chlamydia ☐Gonorrhea ☐ Herpes ☐Other: _____

12. Have you ever been diagnosed with tuberculosis? If YES →when? _____ ☐NO ☐YES

13. At work, have you had unprotected exposure to toxic chemicals or pesticides? ☐NO ☐YES
If YES → What agents have you been exposed to _____

14. Have you ever been exposed to radiation for a long time other than routine XRAYs? ☐NO ☐YES

15. Have you ever had chemotherapy? ☐NO ☐YES

16. Do you take frequent (daily) hot baths, saunas or whirlpools? ☐NO ☐YES

17. Were your born with undescended testicles →what treatment was performed? ☐NO ☐YES

18. Have you ever had a varicocele operation? ☐NO ☐YES
If YES →which side(s): ☐Right ☐Left

19. Have you ever had a hernia operation? ☐NO ☐YES
If YES →which side(s): ☐Right ☐Left

20. Did you ever have a bladder operation? → If YES →what procedure(s) were done? ☐NO ☐YES

21. Have you ever had torsion or twisting of your testicles? ☐NO ☐YES
If YES → Which side(s): ☐Right ☐Left, and when? _____
Did you require surgery to untwist them? ☐NO ☐YES

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22. Have you ever had any other surgery? If YES →what procedure(s) were done? ☐NO ☐YES

23. Do you have: ☐DIABETES ☐HIGH BLOOD PRESSURE ☐HEART DISEASE ☐HIGH CHOLESTEROL

24. Do you have any other major medical illnesses? If YES →what illnesses: ☐NO ☐YES

25. Have you ever smoked TOBACCO? If YES →How many packs per day & years ☐NO ☐YES
smoked _____ Have you stopped smoking ☐NO ☐YES→ when _____

26. Have you ever had a major injury your testicles? If YES →which side(s): ☐Right ☐Left ☐NO ☐YES

27. Have you ever used MARIJUANA? ☐NO ☐YES
If YES →How long used _____
Do You Currently use marijuana ☐NO ☐YES
How frequently ☐DAILY ☐WEEKLY ☐MONTHLY

28. Do you use other recreational drugs? If YES → Which drugs: _____ ☐NO ☐YES

29. Have you ever used anabolic steroids, testosterone or body building drugs? ☐NO ☐YES
If YES →which drugs:_____
Do you currently take these: _____

30. Do you drink alcoholic beverages? ☐NO ☐YES
If YES →How frequently ☐DAILY ☐WEEKLY ☐MONTHLY

31. How old were you when puberty started? _____

32. Do you use lubricant(s) during intercourse? ☐NO ☐YES
If YES →what lubricants? _____

33. Have you had problems with erections? ☐NO ☐YES

34. How often do you have intercourse? _____

35. How often do you have any sexual activity? _____

36. Have any blood relatives had difficulty conceiving children? If YES →who_____ ☐NO ☐YES

WIFE or PARTNER's HISTORY:

37. Has your current partner been diagnosed with an obstruction of her tubes? ☐NO ☐YES
If YES →what treatment(s) has she had:

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38. Does your current partner have (or had) endometriosis? ☐NO ☐YES
    If YES →what treatment(s) has she had:

39. Has your current partner ever had a serious gynecological infection? ☐NO ☐YES

40. Has your current partner needed medication to stimulate her ovaries? ☐NO ☐YES

41. Does your current partner have irregular menstrual cycles? ☐NO ☐YES

42. Does your current partner see a fertility specialist? ☐NO ☐YES
    If YES →who_____, what if any recommendations have been made by the specialist to help you achieve a pregnancy?

Thank you for taking the time to complete this questionnaire.