FERTILITY QUESTIONNAIRE- HUSBAND

Name: ___________________________ Date: ____/____/_____

D.O.B. ____/____/______

A. GENERAL INFORMATION:

1) How long have you been married? _________________
2) How long have you been seeking pregnancy? ________
3) Is this your first marriage? **Yes / No**
4) Do you have children from this marriage? **Yes / No**

   How many children? ______Adopted_______ Biological _______
5) Do you have children from previous marriage(s) or relationship? **Yes / No**

   How many children? ______Adopted_______ Biological _______

B. MEDICAL - SURGICAL:

1) Have you ever had surgery? **Yes / No**

   Procedure Date Place

   ____

   ____
2) Have you recently gained over 20 pounds? **Yes / No**

   If yes, how much? _______________
3) Do you exercise regularly? **Yes / No**

   If yes, how often and what type? _______________________________

TCRH Copyright 2007

4) Are you allergic to any medications? **Yes / No**

   If yes, please list: ____

5) Do you follow any dietary regimen? ____________________________

6) Do you currently use or have you used:

   a. Prescription drugs? **Yes / No** If yes, please list _______________
   ____

   b. Non-prescription drugs or medications? **Yes / No** If yes, please list
   ____

   c. Marijuana or other addictive drugs? **Yes / No**

   d. Tobacco products? **Yes / No** What ________ How often _______

   e. Alcoholic beverages? **Yes / No** What _______ How often _______

<u>Do you have or have you ever had:</u>

( ) Anemia	( ) Thyroid Problems	( ) Headache
( ) Appendicitis	( ) Rheumatic Fever	( ) Ulcer
( ) Arthritis	( ) Gonorrhea	( ) Urethritis
( ) Blood Product Transfusions	( ) Intolerance to Heat or Cold	
( ) Gall Bladder Problems	( ) Heart Disease	
( ) Breast Discharge	( ) Hepatitis	
( ) Excess Sweating	( ) Herpes	
( ) Bronchitis	( ) High Blood Pressure	
( ) Cancer	( ) Syphilis	
( ) Chlamydia	( ) Impotency	
( ) Colitis	( ) Immunizations	
( ) Color Blindness	( ) Liver Problems	
( ) Diabetes	( ) Measles	
( ) Dizziness	( ) Mumps	
( ) Epilepsy (Seizures)	( ) Urinary Tract Infection	
( ) Poor Sense of Smell	( ) Problems with Urination	

Revised 12/01/2004, 05/09/2007
TCRH Copyright 2007

C. PREVIOUS FERTILITY EVALUATION AND TREATMENT:

1) Have you had:

   - ❑ Semen Analysis
   - ❑ Sperm Antibody Assay
   - ❑ Mucous Penetration Assay
   - ❑ Hamster Egg Penetration Assay
   - ❑ Testicular Biopsy
   - ❑ Vasogram

2) Have you previously received fertility medication? **Yes / No**

   If yes, please list name and date___________________________

3) Have you had a hernia repair? **Yes / No**

   If yes, please list the date ________________________________

4) Have you had a varicocele repair? **Yes / No**

   If yes, please list the date ________________________________

5) Do you wear **boxers** or **briefs**?

6) Do you spend any amount of time in a sauna or hot tub more than 2 or 3 times a year? **Yes / No**

   If yes, how often ___________________

TCRH Copyright 2007