

**Urological Associates of Lancaster, LTD.
Infertility Laboratory Questionnaire For Males**

Name _____ Address _____ Age _____

Occupation _____ Duration of infertility _____

Wife's Name _____ Age _____ Years Married _____ Wife's gynecologist _____

What birth control have you used in the past _____

Please answer questions by circling yes or no. If you are not sure, please leave blank.

Marital History:			
1.	Were you previously married?	Yes	No
	Did you have children?	Yes	No
2.	Was your wife previously married?	Yes	No
	Did she have children?	Yes	No
3.	Average number of climax or ejaculations per week	_____	
4.	Do you have pain with intercourse?	Yes	No
5.	Do you have trouble with erections?	Yes	No
6.	Do you have trouble with ejaculation (coming)?	Yes	No
7.	Do you use lubrication or grease for sexual intercourse?	Yes	No
8.	Does your wife douche immediately after intercourse?	Yes	No
9.	Does your wife usually get out of bed after intercourse?	Yes	No
10.	Has your wife been evaluated for infertility?	Yes	No
	Findings:		

Personal History:			
11.	When you were a child, were both testes (balls) descended into the scrotum (sac)?	Yes	No
12.	At what age did you begin shaving regularly?	_____	
13.	Have you ever had:		
	A. Mumps in your testes as an adult	Yes	No
	B. Tuberculosis	Yes	No
	C. Venereal disease	Yes	No
	D. Prostatitis	Yes	No
	E. Epididymitis	Yes	No
	F. Diabetes	Yes	No
	G. Kidney disease	Yes	No
	H. Radiation therapy	Yes	No
	I. Cystic fibrosis	Yes	No
	J. Testis infection	Yes	No
	K. Testis injury	Yes	No
	L. Testis tumor	Yes	No
	M. Muscular dystrophy	Yes	No
	N. Cancer	Yes	No
	O. Varicocele	Yes	No
14.	Have you had any of the following procedures?		
	A. Hernia repair	Yes	No
	B. Vasectomy	Yes	No
	C. Pelvic surgery	Yes	No
	D. Retroperitoneal surgery	Yes	No
	E. Varicocele (varicose veins in scrotum)	Yes	No
	F. Sympathectomy	Yes	No
	G. Penis surgery	Yes	No
	H. Kidney surgery or kidney stone surgery	Yes	No

Name: _____

15.	Are you taking any of the following medications?		
	A. Anti-depressant medications	Yes	No
	B. Tranquilizers	Yes	No
	C. Male hormones	Yes	No
	D. Female hormones	Yes	No
	E. Cancer treatment drugs	Yes	No
	F. Gout medicine	Yes	No
	G. Nitrofurantoin, Furadantin, or Macrochantin	Yes	No
	H. High blood pressure medicines	Yes	No
	I. Other drugs	Yes	No
	Please list:		
16.	Have you had high fever in the last three months?	Yes	No
17.	Have you recently been under much more stress than usual (e.g. new job, problems at home)?	Yes	No
18.	Do you take prolonged hot baths, saunas, or steam baths?	Yes	No
19.	Do you wear tight fitting underwear?	Yes	No
20.	Do you, or have you in the past, regularly use barbiturates, marijuana, LSD, heroin or methadone?	Yes	No
21.	Do you usually drink more than 2 alcoholic beverages (cocktails, beer or wine) per day?	Yes	No
22.	Do you have a family history of infertility?	Yes	No
23.	Have you had previous semen analyses (sperm count)?	Yes	No
	Date _____ Physician _____		
	Findings _____		