UNC Fertility

Male Fertility Evaluation - New Patient Questionnaire

INSTRUCTIONS:
1. The following questionnaire should only take about ten minutes to complete. It will help Dr. Coward to be thorough with your evaluation but also for him to focus on the important individual aspects of your medical history. Please fill out to the best of your knowledge and bring the form with you to your appointment.
2. If you have any previous semen analyses, blood tests, or other evaluations, please attach them to this form.

APPOINTMENT DATE: _____ REFERRING PHYSICIAN: _____
NAME: _____ AGE: _____
PARTNER'S NAME: _____ PARTNER'S AGE: _____
PARTNER'S FERTILITY SPECIALIST:_____
UNC MEDICAL RECORD NUMBER (IF AVAILABLE): _____

FERTILITY HISTORY

How long have you and your partner been trying to achieve a pregnancy? __ months
Have you achieved pregnancy with your current partner? ☐ yes ☐ no
If yes, how many and when? _____
Have you ever achieved a pregnancy with another partner? ☐ yes ☐ no
Has your current partner ever achieved a pregnancy with another partner? ☐ yes ☐ no
Has your partner been evaluated by a gynecologist or fertility specialist? ☐ yes ☐ no
If so, was the evaluation normal? (If not, please specify below) ☐ yes ☐ no
_____

SEXUAL HISTORY

What is the average frequency of intercourse?
☐ < 1 per month ☐ 1-2 month ☐ 1 per week ☐ 2-3 week ☐ Daily
How often do you have intercourse during ovulation? _____
How would you rate your sex drive (libido)? ☐ None ☐ Low ☐ Normal ☐ Excellent
Do you know how to time intercourse to her cycle? ☐ yes ☐ no
Do you use any lubrication? ☐ yes ☐ no
Do you ever have difficulty achieving or maintaining an erection for intercourse? ☐ yes ☐ no
Do you ever have difficulty reaching climax? ☐ yes ☐ no
Do you ever ejaculate (come) too quick or before vaginal penetration? ☐ yes ☐ no

ENVIRONMENTAL EXPOSURES

What is your occupation? _____
Do you smoke cigarettes or use smokeless tobacco? ☐ yes ☐ no
If yes, how many packs/day?_____
Are you a former smoker? ☐ yes ☐ no
If yes, what year did you quit? _____
How many packs/day?_____ Years smoked?_____
Do you drink alcohol on a regular basis? ☐ yes ☐ no
How many drinks/day? _____
Do you use any illegal drugs or non-prescribed prescription medicines? ☐ yes ☐ no
☐ marijuana ☐ cocaine ☐ methadone/narcotics ☐ other _____

Have you ever used pesticides on a regular basis? ☐ yes ☐ no explain:_____
Have you been exposed to toxic chemicals? ☐ yes ☐ no explain:_____
Have you been exposed to radiation (X-rays) regularly? ☐ yes ☐ no explain:_____
Are you exposed to prolonged heat (hot tubs, saunas)? ☐ yes ☐ no explain:_____
Have you ever taken testosterone or anabolic steroids? ☐ yes ☐ no explain:_____
Do you take any work-out supplements? ☐ yes ☐ no explain:_____

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PAST MEDICAL AND SURGICAL HISTORY

Current medical problems:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you ever been treated for cancer? ☐ yes ☐ no explain:_____
Have you had a high fever in the past 6 months? ☐ yes ☐ no explain:_____
Have you ever had any sexually transmitted infections? ☐ yes ☐ no explain:_____
Have you ever had a urinary tract infection? ☐ yes ☐ no explain:_____
Have you ever had epididymitis? ☐ yes ☐ no explain:_____
Have you ever had prostatitis? ☐ yes ☐ no explain:_____
Have you ever had testicular torsion (twist)? ☐ yes ☐ no explain:_____
Have you ever had a serious testicular injury? ☐ yes ☐ no explain:_____
Have you ever been treated for an undescended testicle? ☐ yes ☐ no explain:_____

Previous surgeries:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you had any of the following operations (check all that apply)?

☐ hernia repair	☐ varicocele repair	☐ orchiopexy	☐ urethral stricture
☐ testicular surgery	☐ vasectomy	☐ hypospadias repair	☐ bladder/ureter surgery
☐ hydrocelectomy	☐ testis biopsy	☐ cystoscopy	☐ kidney stone surgery

MEDICATIONS

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you taken any antibiotics in the past 6 months? ☐ yes ☐ no explain:_____
Have you ever used any of the following medications previously?

☐ corticosteroids	☐ sedatives	☐ sulfasalazine	☐ antidepressants	☐ antiseizure meds
☐ HCG injections	☐ Tagamet	☐ spironolactone	☐ antipsychotics	☐ chemotherapy
☐ Clomid	☐ Zantac	☐ ketoconazole	☐ cholesterol meds	☐ immunosuppression

ALLERGIES: _____

FAMILY HISTORY

How many brothers do you have? _____ How many sisters do you have?_____
Are any of your brothers infertile? ☐ yes ☐ no Are any of your sisters infertile? ☐ yes ☐ no
Do any of your family members have cystic fibrosis? ☐ yes ☐ no explain:_____
Do any genetic syndromes run in your family? ☐ yes ☐ no explain:_____
Have any children in your family had birth defects? ☐ yes ☐ no explain:_____

REVIEW OF SYSTEMS

Do you have a normal sense of smell? ☐ yes ☐ no explain:_____
Do you have frequent headaches? ☐ yes ☐ no explain:_____
Has your vision changed recently? ☐ yes ☐ no explain:_____
Have you had a recent change in your energy level? ☐ yes ☐ no explain:_____
Do you have less chest hair than other men in your family? ☐ yes ☐ no explain:_____
What age (approximately) did you go through puberty? _____

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Today's date:	Physician Name:

PATIENT INFORMATION

Patient's Last name: First: Middle:	❑ Mr. ☐ Mrs.	Sex: ☐ M ☐ F	Marital status (circle one) Single / Mar / Div / Sep / Wid

Mailing address:	City:	State:	ZIP Code:

D.O.B: / /	Social Security No.:	Home phone no.: ( )	Cell Phone No.: ( )

Email Address:	Local Pharmacy:	Pharmacy Phone No.:

SPOUSE INFORMATION

Spouse's Last name: First: Middle:	❑ Mr. ❑ Mrs.	Social Security No.:

D.O.B: / /	Phone No.: ( )	Email Address:

REFERRAL INFORMATION

Referred by(Clinic/Doctor):

Referring Clinic/Doctor's Address:	Referring Clinic/Doctor Phone No.:

☐ Family ☐ Friend ☐ Other_____

INSURANCE INFORMATION

(**Please give your insurance card to the receptionist.)**

PRIMARY Insurance:	Group Name(Employer):	Effective Date:	Policy No.:	Group No.:

Subscriber's Name:	Subscriber's D.O.B: / /	Subscriber's Address (***if different***):	Phone No.: ( )

Patient's relationship to subscriber: ❑ Self ❑Spouse ❑ Child ❑ Other

SECONDARY Insurance (***if applicable***):	Group Name(Employer):	Effective Date:	Policy No.:	Group No.:

Subscriber's Name:	Subscriber's D.O.B: / /	Subscriber's Address (***if different***):	Phone No.: ( )

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize REI Clinic or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Informed Consent: Email communication

On occasion, we engage in email communication with our patients. Please review the information below about the limitations and risk of email communication. Please select one of the options below.

While UNC Fertility safeguards your medical records and personal data while it is in our control, we cannot assure, and are not responsible, for the safety of your personal medical information once it leaves our server. UNC Fertility is not responsible for misdirected or incorrectly routed emails due to incorrect or outdated information, email addresses shared with others, or 'send failure' because the email inbox is full.

I have read and understand the above paragraph. I would like to receive emails from UNC Fertility. Email address: _____

_____	_____	_____
Patient Signature	Patient Name	Date

I have read and understand the above paragraph. I would NOT like to receive email communication from UNC Fertility.

_____	_____	_____
Patient Signature	Patient Name	Date