Fertility questionnaire – Patient

Date of first consultation: ……..…… Doctor: …… Referred by: ……

Please complete the following fields or tick the appropriate boxes. Simply mark unclear questions with a question mark.

Surname:

First Name:

Adress:

Phone:

Profession:

Date of birth: ..... **Age:** .....

Are you married to each other?
O No O Yes (since year) .....

Have you already achieved a pregnancy?

O Yes, with current partner
When? - after fertility treatment? O No O Yes

O Yes, with another partner
When? - after fertility treatment? O No O Yes

Have you already experienced infertility with a previous partner?
O No O Yes

Have you already been examined by an andrologist?

O No O Yes (when last?) .....

- What was the outcome?
O Unremarkable O Abnormal

Have you already been prescribed medication by your andrologist?
O No O Yes (which?)

Have you been sterilised?
O No O Yes (when?) .....
- If yes: did you have it reversed subsequently?
O No O Yes (when) .....

Has a sperm analysis (sperm count) already been carried out?
O No O Yes (when last?) .....

- What was the outcome?
O Normal O Abnormal

Do you have erectile dysfunction?
O No O Yes

Have you ever suffered from chronic diseases, metabolic or hormonal disorders?
O No O Yes

- if so, which were these?

Have you had a testicular injury?
O No O Yes (when?) .....

- if yes, how was it treated?

Did you have undescended testicles as a child?
O No O Yes: left O Yes: right

- if yes, how was it treated?
O None O Hormone administration O Operation

Have you had inflammation of the testicles?
O No O Yes (when?) .....

- if yes, how was it treated?

Have you had a testicular tumour?
O No O Yes: left O Yes: right

- When? Left: ..... Right: .....

- What treatment did you receive?

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Have you had varicose veins in the testicles (varicocele)?
O No O Yes

- if so, is that why you had the operation?
O No O Yes (when?) .....

Have tissue samples been taken from your testicles already?
O No O Yes: left O Yes: right

- When? Left: ..... Right: .....

Have you already had other operations in the abdominal or genital area?
O No O Yes (which?) | Year

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What medication are you currently taking?

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Have you ever been found to have a malformation of the vas deferens?
O No O Yes: left O Yes: right

Has your prostate already been examined?
O No O Yes (when?) .....

- What was the outcome?
O Normal O Abnormal

What is your weight and height?
Weight (kilos): ..... Height (cm): .....

Do you have weight fluctuations (> 4 kg)?
O No
O Yes, with increase O Yes, with decrease

Do you do sport?
O Never O Rarely
O Occasionally O Regularly

- If yes, which sports?

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Do you drink alcohol?
O Never O Rarely
O Occasionally O Regularly

Do you smoke?
O No O Yes ..... cigs/day

Do you consume other stimulants (drugs/doping agents)?
O No O Yes

- Which?

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What medication are you currently taking for any allergies?

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Have you had, or do you have any of the following conditions or symptoms?
O No O Yes (which?)

(since) Year

O **Mumps** .....

O **Diabetes** .....
--insulin-dependent O Yes O No

O **High blood pressure** .....

O **Epilepsy** .....

O **Cancer / other tumours**
- Which?
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O **Thyroid disease**
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Do you suffer from any other other illnesses and what medication are you taking for them?
O No O Yes (which?) Medications
..... | .....
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Do you have a family history of hereditary diseases, cancer, other serious illnesses or infertility?
O No
O Yes, on my mother's side (who?)
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O Yes, on my father's side (who?)
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Who is your family doctor?
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Who is your family andrologist?
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Comments:
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