Fertility Center of Dallas
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Reproductive Endocrinology and Infertility
Advanced Gynecologic Endoscopy

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FERTILITY QUESTIONNAIRE - PARTNER

Name:_____ **Date of Birth:**_____ **Age:** _____

A. GENERAL INFORMATION

1) How long have you been married? _____
2) How long have you been seeking a pregnancy? _____
3) Is this your first marriage? _____
4) Do you have children from this marriage? _____
   If yes, How Many Children? Adopted____Biological ___
5) Do you have children from a previous marriage(s) or relationships? If yes, how many children? Adopted___Biological ___

B. MEDICAL/SURGICAL

1) Have you ever had surgery?
   If Yes**, Procedure** _____ **Place** _____ **Date** _____

2) Have you recently lost or gained over 20 pounds? _____
3) Do you exercise regularly? _____
   If yes, how often and what type? _____
4) Do you have follow any special dietary regimen? _____
5) Do you use or have you used: _____
   _____ Prescription drugs or medications? _____
   If yes, please list: _____
   _____ Non- prescription drugs or medications? _____
   If yes, please list: _____

_____ Herbal supplements or alternative medicine?
If yes, please list: _____
_____ Marijuana or other drugs?

_____ Tobacco products?
What?_____How much? _____
_____ Alcoholic beverages?

Do you have or have you ever had:

___ Anemia
___ Appendicitis
___ Arthritis
___ Blood Product Transfer
___ Breast Discharge
___ Bronchitis
___ Hepatitis
___ Herpes
___ High Blood Pressure
___ Impotency
___ Immunizations
___ Epilepsy Seizures
___ Excessive Sweating
___ Gall Bladder Problems
___ Gonorrhea
___ Headache
___ Heart Disease
___ Thyroid Problems
___ Ulcer(s)
___ Problems w/Urination
___ UTI
___ Urethritis
___ Liver Problems
___ Measles
___ Mumps
___ Poor Sense of Smell
___ Rheumatic Fever
___ Cancer
___ Chlamydia
___ Colitis
___ Color Blindness
___ Diabetes
___ Dizziness

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? If yes, please list _____

3) Have you had a hernia repair? If yes, where and when _____

4) Have you had a varicocele repair? If yes, where and when _____

5) Do you wear briefs or boxers? _____

6) Do you spend any amount of time in a sauna or hot tub more than 2 or 3 times a year?
   _____