Austin Fertility & Reproductive Medicine
Westlake IVF

Male Fertility Questionnaire

Name: _____ Age: _____

Age of female partner: _____

Who referred you/how did you hear about us?
Dr. _____ or
Internet _____ or
Friend/Family _____ or

History of Present Illness:
How long have you been trying to achieve a pregnancy? _____

(Yes / No – Circle Answer)

Has your female partner ever been pregnant before? Yes / No

Have you previously conceived with your current partner? Yes / No

Have you previously conceived with another woman? Yes / No

Have you ever been evaluated for infertility before? Yes / No

Have you had any severe illness, surgery, or fevers in the last 3-6 months? Yes / No

Has your female partner had any pelvic infections or pelvic surgery in the past? Yes / No

Does your female partner have regular menstrual cycles? Yes / No

Is your female partner being seen by a fertility specialist (ReproductiveEndocrinologist)? Yes / No

If so, who is the doctor? _____

Have you ever had surgery to fix a hernia as a child or as an adult? Yes / No

Do you have or have you ever had an undescended testicle? Yes / No

Have you ever had testicular torsion (twisting of the testicle)?	Yes / No
Have you had previous injury to your testicles or penis requiring hospitalization or surgery?	Yes / No
Have you ever had any sexual transmitted diseases?	Yes / No
If so what?	
Did you have the mumps after puberty?	Yes / No
Do you feel fatigued?	Yes / No
Do you have any difficulty achieving or maintaining an erection?	Yes / No
Do you have a low sex drive or low desire for sex?	Yes / No
Does your urine ever look cloudy after sex?	Yes / No
How often are you having sex (times per week)?	_____
Do you ever use lubricants during sex?	Yes / No
If so what type?	_____
Do you use hot tubs, warm baths, or saunas?	Yes / No
When using a laptop computer, do you rest it on your lap?	Yes / No
Do you have scrotal or testicular pain?	Yes / No
Do you have difficulty with your peripheral vision?	Yes / No
Do you have a poor sense of smell?	Yes / No
Do you ever have drainage or leakage from the nipples?	Yes / No
Do you have a cough you can not get rid of?	Yes / No
Have you had a semen analysis?	Yes / No
Have you had a vasectomy?	Yes / No
Have you had surgery for a varicocele?	Yes / No

Are you currently on or ever been on testosterone, muscle building supplements, or steroids? Yes/No

If so what kind and when?

Past Medical History:
List any medical problems:

Medications:
List any medications that you take (include prescription, over the counter, herbs, supplements) and doses if known:

Past Surgical History:
List any surgeries that you have had and the dates:

Allergies:
List any medicines that you are allergic to that you know of and what type of reaction you had to that medication:

Family History:
Have any blood relatives had issues with infertility or required assisted reproductive techniques? Yes / No

Have any blood relatives been diagnosed with cystic fibrosis? Yes / No

Social History:
Do you smoke? Yes / No

If so how many cigarettes per day and how many years have you been smoking? _____

Do you drink alcohol? Yes / No

If so how many drinks do you have per day or week? _____

Do you smoke marijuana? Yes / No

If so, how often? _____

Do you use any other illicit drugs? Yes / No

What is your occupation? _____

Are you exposed to any chemicals or toxins at work? Yes / No

Are you married? Yes / No

Spouse/Partner's full name: _____

Review of Systems:

General:
Have you had any fevers, change in weight, or weakness?

Dermatologic:
Have you had any change in skin, hair or nails?

Pulmonary:
Have you had any cough, wheezing, or difficulty breathing?

Endocrine:
Have you had any heat or cold intolerance or any excess hair growth?

Cardiovascular:
Have you had any chest pain, feeling of your heart skipping beats, or swelling in your legs?

Neurologic:
Have you had any seizures, tremors, or numbness?

Psychologic:
Have you had any depression, anxiety, or lack of interest in doing things that you used to enjoy?

Hematologic:
Do you bruise or bleed easily? Have you been diagnosed with anemia?

Gastrointestinal:
Do you have nausea, diarrhea, or constipation?

Genitourinary:
Do you have blood that you can see in your urine, difficulty urinating, or burning when you urinate?

Patient's signature_____ Date _____

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Expanded Genetic Carrier Testing

Expanded genetic carrier means offering to test a list of inherited **recessive gene mutations** to all individuals who are considering pregnancy, regardless of ethnic background. This testing is offered in order to check to the genetic status of an individual in terms of carrying autosomal recessive and X-linked recessive gene mutations, **any of which can be passed along to child(ren) and possibly result in diseases and conditions – even when the intended parent has no symptoms of disease**. According to the American College of Obstetricians and Gynecologists (ACOG), carrier testing and counseling **ideally should be performed and resulted before pregnancy** as this allows couples to learn about their reproductive risk and consider the most complete range of reproductive options.

Examples of diseases for which genetic carrier testing can be performed:

- Cystic fibrosis – progressive multi-systemic disease primarily affecting pulmonary, pancreatic and GI systems; affects 1 in 2,500 individuals in non-Hispanic white population, notably less in other ethnic groups
- Tay-Sachs Disease – testing for individuals of Ashkenazi Jewish, French-Canadian, or Cajun descent; affects 1 in 30 individuals of Ashkenazi Jewish descent, 1 in 300 for non-Jewish individuals
- Sickle Cell Disease (approx. 1 in 10 African Americans carries sickle cell trait), Thalassemias (consider if of African, Mediterranean, Middle Eastern, Southeast Asian, and West Indian descent)
- Spinal Muscular Atrophy (SMA) – disease characterized by degeneration of spinal cord motor neurons leading to atrophy of skeletal muscle and overall weakness; affects 1 in 6,000-10,000 live births, is leading cause of infant death

There is about a **70%** chance that the test will show at least one recessive mutation in one of the partners. If the test shows one partner to be a carrier, the other partner will have the blood/saliva test to see if both partners are carriers of the same recessive condition (**about 2% chance**). If that is the case, you would have the option of doing IVF with Preimplantation Genetic Testing where each embryo you make would be tested for the condition and only embryos without the condition transferred to your uterus.

I acknowledge that I have read the above information and am aware that expanded genetic carrier testing can be ordered and performed per patient request. Please make your recessive disease screening choice know below.

___I choose to be screened

___I decline screening

_____ _____ _____

Partner Date

_____ _____ _____

Partner (if applicable) Date

Created 04/2017; Revised 12/2020

References: ASRM Patient Fact Sheet: Genetic Screening for Birth Defects; ACOG Committee Opinion: Carrier Screening for Genetic Conditions (2017); Dungan et al, Expanded carrier testing: What the reproductive endocrinologist needs to know. Fertil Steril, 2018 Feb;109(2);183-189.