John J. Bauer, M.D., F.A.C.S.
www.flinturology.com
Urology Services, Inc.
G-1121 West Hill Rd.
Flint, Michigan 48507
Tel: 810.232.8888
Fax: 810.232.9190
Email: jbauer@flinturology.com

Evaluation Questionnaire For Male Infertility

Your response to the items on this Questionnaire will allow us to make a preliminary decision about the proper diagnosis and treatment programs. Please use back of paper for more description of each item if needed.

Name:_____ Date:_____

Please describe in your own words your past infertility problem. Include in this description your current problem and how it affects your life. (if more space is needed please use the back of page)

GENERAL QUESTIONS

How long have you and your partner had unprotected sex? _____

How many times do you have vaginal intercourse per week? _____

Do either of you use lubricants or jellies
during intercourse? Yes_____ No_____

FEMALE PARTNER

Has your partner used contraceptives? Yes_____ No_____
How long has she used contraceptives? _____

What type of contraceptives has she used?
Please list the types:

Has your partner ever had an abortion, miscarriage, or pregnancies? Yes_____ No_____
During your present relationship? Yes_____ No_____

During a previous marriage or relationship? Yes_____ No_____

Does your wife/sexual partner have regular periods? Yes_____ No_____
If yes, how many days between periods? _____

Does your partner use a temperature chart? (ovulation chart) Yes_____ No_____

Has your partner ever had pelvic surgery? Yes_____ No_____

Has your partner ever had a tubal patency test? (open tubes dye test) Yes_____ No_____

Has your partner been evaluated by a Gynecologist? Yes_____ No_____

List the medications your partner is currently taking:

MALE PARTNER

General

Has any female ever become pregnant by you in the past? Yes_____ No_____
If yes, when did this occur? _____

Developmental

At what age did you begin to develop pubic hair? _____

At what age did you begin to shave? _____

How many times per week do you shave? _____

Do you shave less now than you did one year ago? Yes_____ No_____

Did you ever have a problem with one or both or your testicles not being in your scrotum? Yes_____ No_____

Sexual Function

Do you have any difficulty in having a climax (orgasm) after you get an erection? Yes_____ No_____

Do you have difficulty getting an erection? Yes_____ No_____

Do you ever have an erection when you wake up in the morning before you urinate? Yes_____ No_____

Infection

Have you ever had any blood in your urine? Yes_____ No_____

Do you have burning when you urinate? Yes_____ No_____

Have you ever had a kidney or bladder infection? Yes_____ No_____

Have you ever had any sexually transmitted diseases? Yes_____ No_____

Did you ever have the mumps as a child? Yes_____ No_____
If yes do you remember if your testicles where swollen? Yes_____ No_____

Cranial Symptoms

Do you have frequent headaches? Yes_____ No_____

Do you have double vision? Yes_____ No_____

Do you have any problem with side vision (peripheral vision)? Yes_____ No_____

Are you color blind? Yes_____ No_____

Do you have difficulty with smelling or tasting things? Yes_____ No_____

Environmental/Occupational

Do you work in a high-temperature environment? Yes_____ No_____

Are you exposed to any chemical agents at work? Yes_____ No_____
If yes, what are they?_____

Gonadotoxins (drugs harmful to testicles)

Do you use any of these drugs?

Cocaine	Yes_____ No_____
Marijuana	Yes_____ No_____
Alcohol(excessively)	Yes_____ No_____
Anabolic steroids	Yes_____ No_____
Any steroid medication	Yes_____ No_____

Medical History / Surgical History

Have you ever had any of the following diseases?

Scrotal lesions (mass, dilated veins)	Yes_____ No_____
Jaundice or liver problems	Yes_____ No_____
Exposure to poisons or dangerous chemicals	Yes_____ No_____
Thyroid problems (Hypo or low)	Yes_____ No_____
Treatment with chemotherapy drugs	Yes_____ No_____
Treatment with radiation	Yes_____ No_____
Kidney disease or absence of kidney	Yes_____ No_____
Lung problems (cystic fibrosis)	Yes_____ No_____

Please list any other medical problems that you may have:

Please list all medications you have been on even over the counter meds:

Have you ever had these surgeries?

Vasectomy (if yes, date:_____)	Yes_____ No_____
Bladder neck resection	Yes_____ No_____
TURP	Yes_____ No_____
Hernia	Yes_____ No_____
Varicoceolectomy	Yes_____ No_____
Any other scrotal surgery	Yes_____ No_____
Removal of testicle	Yes_____ No_____

Major abdominal or pelvic surgery Yes_____ No_____

Please list any other surgery that you have had:

Genetic or Familial Diseases

Has any one in you family ever had any of the following?

Late onset of puberty	Yes_____ No_____
Thyroid problems	Yes_____ No_____
Color blindness	Yes_____ No_____
Kidney Disease or absence of kidney	Yes_____ No_____
Lung problems	Yes_____ No_____

Patient Questions?

If you have any particular questions that are bothering you please write them here!