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## 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?  
If yes, how many days between periods? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

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 of 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 _____
Varicocelectomy	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!