

MALE FERTILITY INFORMATION

History of fathering children:

of children: _____ Term births: _____ Premature Births: _____ Stillbirth: _____

DATE	BIRTH: T = TERM P = PREMATURE	INFERTILITY TREATMENT	OTHER COMPLICATIONS	IS CURRENT PARTNER THE MOTHER?

Sexual history:

- | | | |
|---|---|--|
| <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Genital warts/condyloma |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Testicular trauma | <input type="checkbox"/> Genital herpes |
| <input type="checkbox"/> Low libido | <input type="checkbox"/> Nocturnal emissions (wet dreams) | <input type="checkbox"/> Dizzy/tired after ejaculation |
| <input type="checkbox"/> High libido | Frequency of intercourse: _____x/week/month | |

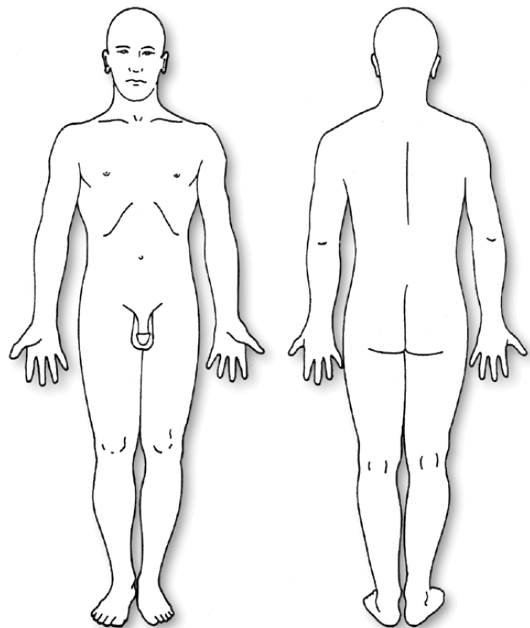
Other information:

- | | | |
|--|--|---|
| <input type="checkbox"/> Varicocele (repaired <input type="checkbox"/>) | <input type="checkbox"/> History of steroid use | <input type="checkbox"/> Exposure to pesticides/chemicals |
| <input type="checkbox"/> Hernia (repaired <input type="checkbox"/>) | <input type="checkbox"/> Cancer/chemotherapy treatment | |

Please indicate on diagram the areas where you are experiencing symptoms according to the key below:

- O = pain
- X = tingling
- = numbness
- ✓ = tics
- ➔ = pain radiates in this direction

Height: _____ Weight: _____



Please check boxes that are relevant to you pertaining to your genito-urinary conditions:

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Cloudy urination | <input type="checkbox"/> Dark yellow urine | <input type="checkbox"/> Burning urination | <input type="checkbox"/> Frequent kidney infections |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Scanty urination | <input type="checkbox"/> Light yellow urine | <input type="checkbox"/> Retention of urine | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Copious urination | <input type="checkbox"/> Urination at night | <input type="checkbox"/> Clear urine | <input type="checkbox"/> Frequent bladder infections | |

History of fertility therapy:

Which of the following tests have you had performed? Check all that apply, and list results if known.

- | | Date of test: (dd/mm/yyyy) | Results: |
|--|----------------------------|----------|
| <input type="checkbox"/> Mycoplasma culture | ___/___/___ | |
| <input type="checkbox"/> Chlamydia culture | ___/___/___ | |
| <input type="checkbox"/> GC culture (gonorrhoea) | ___/___/___ | |
| <input type="checkbox"/> Rubella (German measles) | ___/___/___ | |
| <input type="checkbox"/> Varicella (chicken pox) | ___/___/___ | |
| <input type="checkbox"/> CMV (cytomegalovirus) | ___/___/___ | |
| <input type="checkbox"/> Post-coital test | ___/___/___ | |
| <input type="checkbox"/> Anti-sperm antibodies | ___/___/___ | |
| <input type="checkbox"/> RPR serology (syphilis) | ___/___/___ | |
| <input type="checkbox"/> Prostate exam | ___/___/___ | |
| <input type="checkbox"/> Testosterone | ___/___/___ | |
| <input type="checkbox"/> Post-ejaculatory urine sample | ___/___/___ | |
| <input type="checkbox"/> Sperm analysis | ___/___/___ | |

Results of sperm analysis (below):

<input type="checkbox"/> Low sperm count	<input type="checkbox"/> Poor liquefaction
<input type="checkbox"/> Poor vitality	<input type="checkbox"/> Poor progression
<input type="checkbox"/> High pH <input type="checkbox"/> Low pH	<input type="checkbox"/> Poor sperm morphology
<input type="checkbox"/> White blood cells in semen	<input type="checkbox"/> Red blood cells in semen
<input type="checkbox"/> Low volume of semen	<input type="checkbox"/> Poor motility

Have you ever undergone IUI? Yes No (If yes, your sperm partner's egg donor egg

of IUI's _____ Dates: _____