POUNDBURY FERTILITY

MALE QUESTIONNAIRE

DATE:

(All information disclosed herein is confidential and will not be shared with other parties unless consent is given by the client named below)

(All information disclosed herein is confidential and will not be shared with other parties unless consent is given by the client named below)

NAME:	**PARTNER'S NAME:**
D.O.B:	**D.O.B:**
ADDRESS:	**ADDRESS:**
CONTACT NUMBERS:	**CONTACT NUMBERS:**

<u>MEDICAL HISTORY</u>

Have you ever had any of the following?
If "yes" please provide further details

Undescended testicle	YES / NO
Surgery for hernia	YES / NO
Surgery for prostate enlargement	YES / NO
Surgery for twisted testicle (torsion)	YES / NO
Testicular tumour	YES / NO
Accident involving your genitalia	YES / NO

Varicocele - swelling of veins in testicle YES / NO

Diagnosed sexually transmitted disease YES/ NO

Inflammation of the testicle or epididymis YES / NO

Mumps (age) YES / NO

Cystoscopy YES / NO

Vasectomy reversal YES / NO

Previous radiotherapy YES / NO

Previous chemotherapy YES / NO

SEXUAL HISTORY

Do you have sexual intercourse? YES / NO

Do you have any problems with sex? YES / NO
If "yes" please indicate

Are you able to produce a semen sample by masturbation? YES / NO

Have you ever had a semen test? YES / NO
If yes, when & where

Do we have your consent to obtain the results? YES / NO

Do you have any children with a previous partner? YES / NO

GENERAL HEALTH

What is your occupation? ....

Do you travel away alot? YES / NO

Have you had any serious illnesses in the past? YES / NO
If yes, please give details

Have you had any operations in the past? YES / NO
If yes, please give details

Are you on long term medication? YES / NO
If yes, please give details

Do you smoke? YES / NO
If yes, how many cigarettes a day? ....

Do you drink? YES / NO
If yes, how many units a week? ....

Do you take any recreational drugs? YES / NO
If "yes" what do you use? ....

Do you have any inherited conditions? YES / NO
If yes, please give details

COMPLEMENTARY THERAPIES

Have you ever used any form of complementary therapy? YES / NO
If yes, what and when?

If yes, please give names of practitioners

POUNDBURY FERTILITY

Do we have your consent to contact practitioners? YES / NO

Please make a list below of any questions you would like answered at your consultation below

Thank you for taking the time to complete this form