

Setareh Tais, ND

Phone: 559-470-3435

Male Infertility Profile

Name: _____

Date: _____

Many men will have decreased fertility for unknown reasons. By completing the following comprehensive questionnaire, you will help us identify factors that may influence your health and fertility. This will become a part of your confidential medical record and will not be released unless you have authorized us to do so. Please complete the questionnaire fully.

Male fertility history

How many months have you been trying to achieve pregnancy with your current partner? _____

Have you ever achieved pregnancy in the past? () yes () no

If yes, with () current partner () previous partner

Years of all previous pregnancies _____ () Not applicable

Outcome of pregnancy: () Not applicable

() Uncomplicated vaginal delivery () Cesarean section () Miscarriage () Elective abortion

() Ectopic pregnancy () Premature birth () Stillbirth () Birth defects () Other: _____

Has anyone in your family experienced problems with fertility? () Yes () No

If yes, explain: _____

Have you been previously evaluated for infertility? () yes () no

If yes, name of Physician: _____ Year of evaluation: _____

Findings/Diagnosis/Treatment: _____

With your current partner, how many months have you used contraception prior to trying to conceive: _____

What has been your most recent form of contraception: _____

Methods used in the past: _____

Do you have any non-fertility related health problems? () yes () no

If yes, explain: _____

Are you taking any non-fertility related medication? () yes () no

Sexual history

Do you have problems with sexual desire? () yes () no

Do you have problems with erections? () yes () no

If yes, () problems with maintaining erections () premature ejaculation

Do you have early morning erections? () yes () no

Can you obtain an erection with masturbation? () yes () no

Do you have problems with ejaculation? () yes () no

If yes, () dry ejaculation () low volume ejaculation () painful ejaculation () bloody ejaculation ()

Other: _____

Do you use lubrication with intercourse? () yes () no

Have you ever had white, green or yellow discharge from the end of your penis? () yes () no

Have you ever had pain or swelling in your testicles? () yes () no

Have you ever had a urinary tract infection? () yes () no

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Has your partner had problems with recurrent vaginal infections? () yes () no
 Have you or your partner had any of the following diseases? () herpes () pelvic inflammatory disease (PID)
 () gonorrhea () chlamydia () urethritis () syphilis () HIV () genital warts/HPV () none

Family and Genetic History

Please answer the following medical history questions about yourself, your partner and your relatives. Please consider all family members related to you or your partner by blood. Consider parents, siblings, half-siblings, grandparents, aunts, uncles, nieces, nephews, cousins and children you have had.

Check "yes" if the condition has occurred in you, your partner and/or any of your relatives. Additional space is provided below.	Male and his family		Female and her family	
	Yes <input type="checkbox"/>	Who?	Yes <input type="checkbox"/>	Who?
Open spine defects (spina bifida, anencephaly)				
Heart defect				
Cleft lip and/or palate				
Other birth defects				
Chromosome condition (Down's syndrome, translocation carrier)				
Blood disorder (sickle cell anemia, thalassemia, hemochromatosis)				
Bleeding disorder (hemophilia)				
Cystic fibrosis				
Other inherited or genetic condition				
Cancer (before age 50 years)				
Three or more miscarriages				
Stillborn baby or baby that died within the first year				
Premature menopause				
Infertility				
Other				

For any of the above answered "yes", please specify the condition?

Are you and your partner related by blood? () yes () no

If yes, how are you related? _____

Ethnicity

Are you of Caucasian ancestry? () yes () no

If yes, have you been tested as a carrier of cystic fibrosis? () yes () no Results: () carrier () non-carrier

Are you of French Canadian ancestry? () yes () no

If yes, have you been tested for Tay Sachs disease? () yes () no Results: () carrier () non-carrier

Are you of Jewish ancestry? () yes () no

If yes, have you been tested as a carrier for () Tay Sachs disease () Gaucher's disease () Nieman-Pick

() Canavan's disease () Fanconi anemia () Bloom syndrome () Dysautonomia

Results: () non-carrier () carrier of _____

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Are you of Black ancestry? () yes () no

If yes, have you been tested for sickle cell disease? () yes () no Results: () carrier () non-carrier

Are you of Caribbean, Mexican, or Central American ancestry? () yes () no

If yes, have you been tested for thalassemia? () yes () no Results: () carrier () non-carrier

Are you of Greek, Italian or Middle Eastern ancestry? () yes () no

If yes, have you been tested for thalassemia? () yes () no Results: () carrier () non-carrier

Are you of Asian ancestry? () yes () no

If yes, have you been tested for thalassemia? () yes () no Results: () carrier () non-carrier

Social history

Do you smoke tobacco? () yes () no If yes, specify how much/often:

Do you drink alcoholic beverages? () yes () no If yes, specify type/amount/frequency:

Do you use recreational drugs? () yes () no If yes, specify type/amount/frequency

At work are you exposed to: () pesticides () radiation () industrial solvents () plastics

General medical history

Have you ever had an operation for: () Hernia () Hydrocele () Testicle biopsy () Varicocele () Vasectomy
() Undescended testes () Other: _____

Partner's history (If your current partner is not a patient in our fertility program, please complete this section)

What is her age: _____

Has she ever achieved pregnancy in the past? () yes () no

If yes, with () with you () previous partner

Years of all previous pregnancies _____ () Not applicable

Outcome of pregnancy: () Not applicable

() Uncomplicated vaginal delivery () Cesarean section () Miscarriage () Elective abortion

() Ectopic pregnancy () Premature birth () Stillbirth () Birth defects () Other: _____

Has anyone in her family experienced problems with fertility? () Yes () No

If yes, explain: _____

Has she been evaluated for infertility? () yes () no

If yes, name of Physician: _____ Year of evaluation: _____

If yes, what tests were performed? () Pelvic ultrasound () Hysterosalpingogram () Laparoscopy

() Basal body temperature () Urinary ovulation test () Cervical mucus testing () Endometrial biopsy

() Blood tests: _____ () I don't know ()

If yes, what diagnosis has she been given? () Irregular ovulation () Blocked fallopian tubes

() Endometriosis () Uterine fibroids () Abnormal cervical mucus or opening () Autoimmune disease

() Blood clotting disease () Fertile or unexplained infertility () Other: _____

Is she currently receiving or planning to receive infertility treatment? () No () Antibiotics () Hormones

() Ovulation induction () Surgery () Intrauterine insemination () In vitro fertilization

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Your personal philosophy

Have you and your partner discussed the level of intervention you are willing to try to have a baby? () yes () no and we have decided to consider...

- () Natural Interventions only
- () Natural Interventions plus safe, more gentle medications
- () A trial of natural interventions, then IVF and other conventional procedures if necessary
- () If not able to have biological children, that's ok, at least we tried
- () If not able to have biological children, we would love to adopt
- () Other conclusions: _____

Anything else about you that I should know?

Any specific questions you have?