Arizona Reproductive Medicine Specialists

Infertility Questionnaire **BE SURE TO FILL OUT DETAILS ON THE RIGHT**

Personal Info Today's Date _____
Name _____ Age _____ Male

Name _____ Age _____Female

What is the reason for your visit? _____
Why are you freezing sperm? _____

COUPLE **Details for items marked should be written in the spaces to the right.** ►►►►►►►►►►►►►

Years married/living together _____ ►
Years of unprotected intercourse _____ ►
Do you have any children together? □Y □N
Youngest's age _____
Miscarriages? □Y □N Abortions? □Y □N ►
Any problems with intercourse? □Y □N ►
Past infertility treatments? □Y □N Explain if yes ►

MALE

History

Have you ever caused a pregnancy? N □ Y □ ►
When was the last time? _____ years
Age developed pubic hair? _____ Began shaving? ____
Smoke? □Y □N Greater than 2 packs/week? □Y □N
Alcohol? □Y □N How much per week? _____
Caffeine? □Y □N How much? _____
Recreational Drugs? □Y □N Types _____
Frequency of intercourse per month _____
Exposure to (check all that apply and explain):
Chemo □ Poisons □ Heat □ X □-Rays ►
Lead □ Steroids □ _____ Other □

Medical History (Check and date those that apply) ►
_____ Cancer □ _____ Undescended testicle □
_____ Impotence □ _____ Low sex drive □
_____ Mumps □ High Bl □ood Pressure _____
_____ Ulcers □ _____ Venereal Disease□
_____ Diabetes □ _____ Abdominal Surgery □
_____ Arthritis □ _____ Tuberculosis □
_____ Prostate, penile, kidney or urinary infections □
_____ Surgeries □ High Fevers □ _____
_____ Major Illnesses □

Medications
Are you on any prescribed medications? □Y □N ►
Have you been on any in the last 6 months? □Y □N ►
Are you on any over the counter meds? □Y □N ►
Any herbals, muscle builders or vitamins? □Y □N ►
Any allergies or reactions to medications? □Y □N ►

Past Fertility
Have you ever visited a urologist? □Y □N ►
Have you ever had a hormone analysis? □Y □N ►
Have you ever had a semen analysis? □Y □N ►
Past Semen Analysis Details
Date Count Motility Volume Morpholgy

Phone Number (___)_____
◄Male S.S.# _____

◄Female S.S.# _____

Dr. That Referred You? _____

Details (Dates, results, etc.)

List any problems with intercourse or sexual drive:

Explain exposure history to heat, x-rays, steroids, poisons, lead or chemicals:

Explain any checked portions of your medical history:

Cancer type:

List any medications, vitamins or herbals:

List reason for past infertility investigation and any results:

Arizona Reproductive Medicine Specialists

Infertility Questionnaire **BE SURE TO FILL OUT DETAILS ON THE RIGHT**

FEMALE

History

Have you ever been pregnant? N☐ Y☐ ►

When was the last time? _____ years

With your current partner?N☐ Y☐

Miscarriages? ☐Y ☐N Abortions? ☐Y ☐N ►

Age developed pubic hair? _____

Age first period? _____ Age regular periods? _____

Smoke? ☐Y ☐N Greater than 2 packs/week? ☐Y ☐N

Alcohol? ☐Y ☐N How much per week? _____

Caffeine? ☐Y ☐N How much? _____

Recreational Drugs? ☐Y ☐N Types _____

Frequency of intercourse per month _____

Any discomfort with intercourse? ☐Y ☐N ►

Lubricants used during intercourse? ☐Y ☐N ►

Any recent changes in your sexual drive? ☐Y ☐N ►

What was the first day of your last period? _____

Any discomfort associated with your period? ☐Y ☐N

Have you had any past infections/irritations of your pelvic organs? ☐Y ☐N

Did your mother take DES when she was pregnant with you? ☐Y ☐N

Medical History (Check and date those that apply) ►►

_____ Rubella ☐ _____ High Blood Pressure ☐

_____ Cancer ☐ _____ Low sex drive ☐

_____ Diabetes ☐ Ve☐nereal Disease _____

_____ Arthritis ☐ _____ Abdominal Surgery ☐

_____ TB ☐ _____ Steroids ☐

_____ Kidney or urinary infections ☐

_____ Surgeries ☐ _____ High Fevers ☐

_____ Major Illnesses ☐_____

Medications

Are you on any prescribed medications? ☐Y ☐N ►

Have you been on any in the last 6 months? ☐Y ☐N ►

Are you on any over the counter meds? ☐Y ☐N ►

Any herbals, muscle builders or vitamins? ☐Y ☐N ►

Any allergies or reactions to medications? ☐Y ☐N ►

Past Fertility

Basal Body Temperature? ☐Y ☐N ►

Ovulation Prediction Kit? ☐Y ☐N ►

Hormonal Tests? ☐Y ☐N ►

Post Coital Test? ☐Y ☐N ►

Endometrial Biopsy? ☐Y ☐N ►

Hysterosalpingogram (HSG)? ☐Y ☐N ►

Diagnostic Laparoscopy? ☐Y ☐N ►

Other _____

_____

Details (Dates, etc.)

List any problems with intercourse or sexual drive:

List details of medical history:

List all medications, vitamins or herbals:

List fertility tests and the results of those tests: