JOHN MUIR HEALTH

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Urology Infertitlity Questionnaire

Patient Name: ______________________________ Date of Birth: __________ Today's Date: __________
First Middle Initial Last

Physician Who Referred you? ______________________________

Some of the following questions are very personal. They are not intended to pry needlessly into your health, marital or sexual history. Each of them has a specific relationship to infertility problems.

MALE

Date of Birth: _____/_____/_____
Month Day Year

Highest Level of Education: ____________________

Religion: ____________________

Ethnicity: (Check one or more) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined

FEMALE

Date of Birth: _____/_____/_____
Month Day Year

Highest Level of Education: ____________________

Religion: ____________________

Ethnicity: (Check one or more) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined

MALE MEDICAL HISTORY:	No	Yes	If Yes, When
High Blood Pressure (Hypertension)	❑	❑	
Kidney Problems	❑	❑	
Infection of Prostate	❑	❑	When/Where?
Infection of the Testicles or Epididymis	❑	❑	
Blood in the Ejaculation (semen)	❑	❑	
Have you had an infection of your urinary tract?	❑	❑	
Do you urinate frequently?	❑	❑	
Do you have to get up at night to urinate?	❑	❑	
Do you ever leak urine? (incontinence)	❑	❑	
Have you ever had a venereal infection? (VD, gonorrhea, syphilis)	❑	❑	
Have you ever had white, green or yellow discharge from the end of your penis?	❑	❑	
Have you ever had mumps?	❑	❑	
a) Did it affect your testicles?	❑	❑	
Have you ever had any of the following?			
a) Diabetes	❑	❑	
b) Cancer	❑	❑	
c) Neurologic Disorders	❑	❑	
d) Radiation Therapy	❑	❑	
e) Heart Problems	❑	❑	

Patient Name: ____ Date of Birth: ___________ Today's Date: ___________
First Middle Initial Last

MALE MEDICAL HISTORY Cont.:	No	Yes	If Yes, When
Have you ever had surgery for the following?			
a) Vasectomy	☐	☐	
b) Varicocele (varicose vein in the scrotum)	☐	☐	
c) Penis Surgery	☐	☐	
d) Prostate Surgery	☐	☐	
e) Testicle Surgery	☐	☐	
Have you ever had a hernia surgery?	☐	☐	
Did you have undescended testicles at birth?	☐	☐	
Have you had any other surgery?	☐	☐	
Have you had any illness requiring hospitalization?	☐	☐	
a) Illness:			
b) Illness:			
c) Illness:			
Have you ever had trauma (injury) to your testicles?	☐	☐	
Do you frequently take hot baths, saunas, steam baths?	☐	☐	
Do wear jockey shorts?	☐	☐	
At what age did you start to shave? _________			
a) How often do you need to shave?	___________		
b) How does your beard compare to other males?	___________		
Have you had a high fever in the past three (3) months?	☐	☐	
Medication and Drugs	**No**	**Yes**	
Do you smoke?	☐	☐	
Do you now or have you used any of the following drugs?			
a) Alcohol	☐	☐	
b) Marijuana	☐	☐	
c) Other Street Drugs	☐	☐	
Are you currently taking any prescribed medications?	☐	☐	
a) Medication: ___________ Amount: ___________			Frequency: ___________
b) Medication: ___________ Amount: ___________			Frequency: ___________
c) Medication: ___________ Amount: ___________			Frequency: ___________
Do you have allergies?	☐	☐	
If yes, what medication do you take for it? ___________			
Do you have any allergies to medications?	☐	☐	
a) Medication:_______________________			Reaction:_______________________
b) Medication:_______________________			Reaction:_______________________
c) Medication:_______________________			Reaction:_______________________
Have you ever taken any steroids (Prednisone,cortisone)?	☐	☐	
a) Medication:_______________________			
b) Medication:_______________________			

Patient Name: ____ Date of Birth: ___________ Today's Date: ___________

First Middle Initial Last

Work History	No	Yes	
Occupation:____			
Have you ever been exposed to any of the following:	☐	☐	
a) Chemicals or solvents & fumes (Agent orange)	☐	☐	
b) Temperature extremes (cold or extreme heat)	☐	☐	
c) X-rays or radioisotopes	☐	☐	
d) Lead or lead products?	☐	☐	
Is your occupation stressful?	☐	☐	
Do you need to meet rigid deadlines or the time schedules?	☐	☐	
Do you travel frequently?	☐	☐	
Do you sleep well at night?	☐	☐	
Sexual History	**No**	**Yes**	
How frequently do you have intercourse? Times per week: _______			
How often do you ejaculate? Times per week: _______			
Do you obtain an erection easily?	☐	☐	
Do you often have erections in the morning?	☐	☐	
Do you maintain your erection sufficiently for intercourse?	☐	☐	
Have you ever ejaculated through a flaccid penis?	☐	☐	
Do you ever ejaculate prior to penetration for intercourse?	☐	☐	
Is intercourse ever painful for you?	☐	☐	
Is intercourse painful for your partner?	☐	☐	
Do you use any form of lubrication for intercourse?	☐	☐	
Had your partner ever used any contraceptives?	☐	☐	Type(s):
Is your partner subject to vaginal infections?	☐	☐	Frequency:
Does your partner douche immediately following intercourse?	☐	☐	
History of Previous Fertility	**No**	**Yes**	
How long have you and your partner been trying to have a child? ___________			
Have you and your partner had a previous child together?	☐	☐	Child's Age:
Has your partner ever had a miscarriage?	☐	☐	
Have you ever had any children with another partner?	☐	☐	How many? Age(s):
Have you previously been tested for fertility?	☐	☐	When:
a) Where: ______________________			
b) Did you undergo any treatment?	☐	☐	Type:
Has your partner undergone any fertility evaluations?	☐	☐	
Has your partner ever been treated for infertility?	☐	☐	
Do you have intercourse every other day during ovulation?	☐	☐	
Does your partner use a basal body temperature chart?	☐	☐	
Do you understand how to use it?	☐	☐	
Does your partner use an ovulation kit?	☐	☐	

Patient Name: ____ Date of Birth: _____________ Today's Date: _____________
First *Middle Initial* *Last*

History of Previous Fertility Cont.	No	Yes	
Does your partner usually get out of bed immediately following intercourse?	❑	❑	
Who is your partner's physician?			Name:
Do you have any family history of infertility?	❑	❑	

FAMILY HISTORY				
RELATION	**AGE(S)**	**STATE OF HEALTH**		**IF DECEASED, CAUSE/AGE OF DEATH**
Mother				
Father				
Siblings				
Spouse				
Children				
Are you of Ashkenazi Jewish descent?		**YES** ❑	**NO** ❑	

Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.	
Disease	**Family member**

SOCIAL HISTORY		
(✓)	**SUBSTANCE:**	**APPROXIMATE YEAR STARTED / FREQUENCY:**
❑	ALCOHOL	Year: ☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always
❑	SMOKING STATUS	❑ Current/Every Day ❑ Current/Some Days ❑ Former Smoker ❑ Never Smoker ❑ Unknown
❑	TOBACCO	Year: Pack(s) A Day: Quit: ☐ NO ☐ YES *If YES*, Date Quit:
❑	STREET DRUGS/OTHER	Year: Type: Do you use needles? ❑ YES ❑ NO
❑	HIV positive or AIDS	☐ YES ☐ NO

Patient Name: ____ Date of Birth: _____________ Today's Date: _____________
First *Middle Initial* *Last*

CURRENT MEDICATION LIST

DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES

☐ None ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Cipro ☐ Macrobid

☐ Other (List All):

MEDICATION	SPECIFIC TYPE OF REACTION

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to Pacific Urology to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

***** SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY

Name & Address (Location) of Preferred OUTSIDE Pharmacy: **Is this is a MAIL ORDER PHARMACY? ❑ Yes ❑ No**

Please list a local pharmacy for urgent prescriptions if primary is a mail order.
Name & Address/Phone of LOCAL pharmacy: