Male Fertility Questionnaire

SYNERGY
acupuncture & wellness
working together toward better health

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be held absolutely confidential*. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "Comments" section. ***Whenever possible, please provide a copy of lab reports.*** Thank you.

Name	Age:	Date
Name of fertility doctor/specialist:		Contact Number:

Fertility History:

How long have you been trying to conceive with your partner?
Have you had any diagnosis relating to fertility? ☐ No ☐ Yes If yes, please explain.
Have you had any fertility treatments? ☐ No ☐ Yes If Yes, please provide additional information below: Date of procedure(s): Type of procedure(s): Administering physician(s):
Have you fathered any children? ☐ No ☐ Yes If yes, when? With your current partner? ☐ No ☐ Yes
Have you had a Semen Analysis?? ☐ No ☐ Yes Date: Results:
Have you been examined by a urologist? ☐ No ☐ Yes Results:
Have you had any microsurgery or other operations? ☐ No ☐ Yes Results:
Have you had any hormonal blood-work evaluations? ☐ No ☐ Yes Results:
Have you had any other diagnostic procedures? ☐ No ☐ Yes Procedure(s): Results:

Male Fertility Questionnaire (continued)

Health History:

At what age did you begin puberty?
Have you ever suffered a trauma to your reproductive organs? ☐ No ☐ Yes Date: Describe:
Have you ever had a kidney infection? ☐ No ☐ Yes Date:
Have you ever had a urinary tract or bladder infection? ☐ No ☐ Yes Date:
Have you ever had inflammation of the prostate? ☐ No ☐ Yes Date:
Have you ever had any testicular masses or nodules? ☐ No ☐ Yes Date
Have you ever had a hernia? ☐ No ☐ Yes Date:
Do you have a history of undescended testes? ☐ No ☐ Yes When did it resolve?
Did you have mumps as a child? ☐ No ☐ Yes
Was your mother exposed to DES while pregnant with you? ☐ No ☐ Yes
Have you been treated for any sexually transmitted disease? ☐ No ☐ Yes Date: Describe:
Have you had any recent illnesses, colds or flus? ☐ No ☐ Yes Date: Describe:
Have you been diagnosed with any other medical conditions? ☐ No ☐ Yes Date: Describe:

Lifestyle:

Do you smoke? ☐ No ☐ Yes If yes: # of cigarettes/ packs per day:
Do you drink alcohol? ☐ No ☐ Yes If yes: # of drinks per week:
Do you use a hot tub? ☐ No ☐ Yes If yes: # of times per week:
Have you had any exposure to known environmental toxins? ☐ No ☐ Yes Please describe:
Do you use recreational drugs? ☐ No ☐ Yes If yes: # of times per week:
Have you had any exposure to steroidal hormones? ☐ No ☐ Yes Please describe: