Southwest Florida Urologic Associates
COMPASSIONATE PHYSICIANS/COMPREHENSIVE CARE
12631 Whitehall Drive Ft. Myers, Florida 33907 (239) 939-4444

INFERTILITY QUESTIONNAIRE

GENERAL INFORMATION

1. **Name:**_____ **Dob:**_____

   Marital Status_____ **Any Children:**_____
   Previously Married: Yes( ) No ( ) **Any Children:**_____

   Current Address:_____
   City : _____ **State:**_____**Zip:**_____

   Telephone #:_____ **Cell Phone:**_____

2. **Occupational History**
   Present
   Occupation_____
   Number of Years Worked_____
   Previous Occupation (Past Ten Years)
   _____
   _____

SEXUAL HISTORY

1. **Do you have problems with erections or ejaculation?** **Yes** **No**
   If yes, please give details:_____
   _____
   _____

2. **What is your frequency of sexual intercourse?:**_____
3. **Do you time intercourse with your partner's ovulation?** **Yes** **No**
4. **Do you routinely use lubricants?** **Yes** **No**
   If yes, what kind? :_____

HISTORY OF EXPOSURE TO:

1.	Solvents, Dyes, Chemicals, Pesticides, Etc?	Yes	No
2.	Excessive Heat?	Yes	No
3.	Excessive Smoke?	Yes	No
4.	Radiation?	Yes	No

HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING DRUGS OR MEDICATIONS?

1.	Marijuana	Yes	No
2.	Cocaine	Yes	No
3.	Other narcotics or "street drugs"	Yes	No
4.	Tagamet (cimetidine)	Yes	No
5.	Macrodantin (nitrofurantoin)	Yes	No
6.	Alcohol to excess	Yes	No
7.	Steroids	Yes	No
8.	Chemotherapy drugs for cancer	Yes	No

Describe the approximate time and duration of exposure to any of the above.

_____

_____

_____

SURGICAL HISTORY

Have you ever had the following and /or surgical repair?

1.	Undescended testicles	Yes	No
2.	Testicular torsion (twisted testicle)	Yes	No
3.	Hernia repair (groin)	Yes	No
4.	Trauma (injury) to testicle/scrotum	Yes	No
5.	Prostate or bladder surgery	Yes	No
6.	Testicular cancer	Yes	No
7.	Fractured pelvis	Yes	No
8.	Abdominal surgery	Yes	No

MEDICAL HISTORY

Do you have any medical history of the following?

1.	Diabetes mellitus	Yes	No
2.	Stroke	Yes	No
3.	Multiple sclerosis	Yes	No
4.	Extended viral illness (mumps/measles)	Yes	No
5.	Venereal disease (gonorrhea)	Yes	No
6.	Orchitis (infected testicle)	Yes	No
7.	Cystic fibrosis (or family history)	Yes	No
8.	Delayed puberty	Yes	No
9.	Endocrine problems (pituitary, adrenal, thyroid gland)	Yes	No

Describe any treatments you have had for any of the above illnesses. _____

_____

_____

INFERTILITY HISTORY (MEDICAL)

1. How long have you been trying to conceive with Conception?_____

2. Any pregnancies by your present sexual partner? Yes No

3. Any pregnancies by previous sexual partners? Yes No

4. Have you been previously treated for Infertility? Yes No

5. Have you had a previous semen analysis? Yes No

   If yes, results:_____

6. Has your present partner ever been/or is being treated for infertility? Yes No

7. Who is your partner's OB/GYN physician _____