



Fertility Specialists  
of  
San Diego

# Fertility Specialists Medical Group

&

## San Diego Center for Reproductive Surgery

8010 Frost Street, Plaza Level, San Diego, CA 92123



San Diego Center  
for  
Reproductive Surgery®

### MALE PRE-CONSULT QUESTIONNAIRE

#### 1. IDENTIFYING INFORMATION

Date this form completed \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Significant Other Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Primary Language spoken:  English  Spanish  Other: \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Care MD \_\_\_\_\_

How long have you been attempting conception? \_\_\_\_\_ Number of years married/together \_\_\_\_\_

Reasons you are coming to see us: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### 2. PREGNANCY HISTORY (that you have been responsible for) None

Date	Mis-carriage?	Elective Abortion?	Months to conceive?	Infertility Treatment?	Weight and sex?	Complications?
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____

#### 3. OPERATIONS AND HOSPITALIZATIONS

Date	Diagnosis	Operation	Where	Physician
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

#### 4. MEDICATIONS *List all prescriptions and over-the-counter drugs used during the past year*

Date	Dose and frequency	From when to when	Reason
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

#### 5. ALLERGIES

Drug or substance	Reaction
1. _____	_____
2. _____	_____

**6. OTHER HISTORY**

Your occupation:..... Alcohol - type and number per week:.....  
 Cigarettes - packs smoked per day:..... Marijuana - amount: .....  
 Other drugs - type and amount: ..... Jacuzzi  yes  no IF yes, #/week: .....  
 Ever used intravenous drugs?  yes  no Radiation exposure:  yes  no

**7. MEDICAL ILLNESSES**

Do you have or have you had?

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Kidney disorder           | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> Rubella                   | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Hypertension          | <input type="checkbox"/> Bronchitis                 | <input type="checkbox"/> Anesthetic complication   | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> High cholesterol      | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Mumps                     | <input type="checkbox"/> Blood clots          |
| <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Hepatitis / liver disorder | <input type="checkbox"/> Chicken pox               | <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> Rheumatic fever       | <input type="checkbox"/> Gall bladder problems      | <input type="checkbox"/> Mononucleosis             | <input type="checkbox"/> Bleeding disorder    |
| <input type="checkbox"/> Scarlet fever         | <input type="checkbox"/> Ulcers                     | <input type="checkbox"/> Serious injury / accident | <input type="checkbox"/> Thyroid disorder     |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Colitis / enteritis        | <input type="checkbox"/> Blood transfusion         | <input type="checkbox"/> Recent immunization  |
| <input type="checkbox"/> Heart murmur          |   |  |   |

Please explain a "Yes" answer to any of the above \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8. SYSTEMIC REVIEW**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Maximum Weight \_\_\_\_\_ Minimum Weight \_\_\_\_\_ Weight change in last 2 yrs \_\_\_\_\_

Do/have you participated in any significant dietary changes over the past 3 years?.....

Do/have you participated in any vigorous exercise programs over the past 3 years?.....

If so please document : Vigorous exercise: type ..... hrs/week .....

- The effect of being overweight on male fertility have been well documented.
- Please speak with your physician regarding weight loss attempts and ideal weight range for you height.
- Obesity does not usually cause infertility but obesity may have significant impact on treatment responses

Headaches: Number per week \_\_\_\_\_ Medication used \_\_\_\_\_

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Wear glasses         | <input type="checkbox"/> Bladder/kidney infections             | <input type="checkbox"/> Abdominal pain          | <input type="checkbox"/> Acne                      |
| <input type="checkbox"/> Wear contact lenses  | <input type="checkbox"/> Urgent / frequent / painful urination | <input type="checkbox"/> Nausea and vomiting     | <input type="checkbox"/> Skin disorder             |
| <input type="checkbox"/> Sinus problems       | <input type="checkbox"/> Blood / abnormal color of urine       | <input type="checkbox"/> Vomiting blood          | <input type="checkbox"/> Rash                      |
| <input type="checkbox"/> Hayfever             | <input type="checkbox"/> Unable to control urination           | <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Hives                     |
| <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Abnormal urinary tract                | <input type="checkbox"/> Food intolerance        | <input type="checkbox"/> Skin cancer               |
| <input type="checkbox"/> Hearing loss         | <input type="checkbox"/> Kidney x-ray                          | <input type="checkbox"/> Gallstones              |  |
| <input type="checkbox"/> Denture / bridges    | <input type="checkbox"/> Bladder cystoscopy                    | <input type="checkbox"/> Jaundice / hepatitis    |  |
| <input type="checkbox"/> Counseling           | <input type="checkbox"/> Chronic constipation                  | <input type="checkbox"/> Recent stress increase  |  |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Varicose veins                        | <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Recent anxiety increase   |
| <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Easy bruising                         | <input type="checkbox"/> Blood in bowel movement |  |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Prolonged bleeding                    | <input type="checkbox"/> Irritable bowel         | <input type="checkbox"/> Sensation loss / numbness |
| <input type="checkbox"/> Fainting spells      | <input type="checkbox"/> Bleeding from gums                    | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Muscle control / weakness |
| <input type="checkbox"/> Leg swelling         | <input type="checkbox"/> Nosebleeds                            | <input type="checkbox"/> Hernia                  | <input type="checkbox"/> Heat or cold intolerance  |
| <input type="checkbox"/> Calf pain            | <input type="checkbox"/> Take aspirin/ibuprofen frequently     | <input type="checkbox"/> Abnormal liver test     | <input type="checkbox"/> Damp skin                 |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Unusual hair loss                     |  |  |
| <input type="checkbox"/> Cough                | <input type="checkbox"/> Chest x-ray / TB skin test            | <input type="checkbox"/> Back pain               | <input type="checkbox"/> Extraordinary fatigue     |
| <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Cough up blood                        | <input type="checkbox"/> Wheezing                |  |

**OTHER:** \_\_\_\_\_  
 \_\_\_\_\_

If yes, please comment: \_\_\_\_\_

**9. FAMILY HISTORY / GENETIC HISTORY**

	Mother	Father	Brothers: #	Sisters: #	Children: #	Other
Cancer (type)						
Diabetes						
Hypertension						
High Cholesterol						
Heart Disease						
Stroke						

**10. ETHNICITY** \*Data will be used for genetic testing recommendation purposes

- Caucasian   
  Hispanic   
  Asian   
  African American   
  Other ( \_\_\_\_\_ )

**Do you or anyone in either family have?**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Neural tube defects/spina bifida/anencephaly | <input type="checkbox"/> Cystic fibrosis               | <input type="checkbox"/> Tay-Sachs disease            | <input type="checkbox"/> Chromosomal disorder         |
| <input type="checkbox"/> Thalassaemia                                 | <input type="checkbox"/> Muscular dystrophy            | <input type="checkbox"/> Sickle cell disease or trait | <input type="checkbox"/> Genetic / inherited disorder |
| <input type="checkbox"/> Down syndrome                                | <input type="checkbox"/> Huntington chorea             | <input type="checkbox"/> Hemophilia                   | <input type="checkbox"/> Baby with birth defects      |
| <input type="checkbox"/> Hydrocephalus                                | <input type="checkbox"/> Mental retardation / fragileX | <input type="checkbox"/> Hormonal disorder            | <input type="checkbox"/> Infertility                  |
| <input type="checkbox"/> Stillbirth                                   | <input type="checkbox"/> Epilepsy or seizures          | <input type="checkbox"/> Kidney disease               | <input type="checkbox"/> Mental illness               |
| <input type="checkbox"/> 3 or more miscarriages                       | <input type="checkbox"/> Phenylketonuria               | <input type="checkbox"/> Neurofibromatosis            | <input type="checkbox"/> Myotonic dystrophy           |
| <input type="checkbox"/> Diabetes                                     |  |   |   |
- Any birth defects?       Any inherited disorders?

Please explain a "Yes" answer to any of the above \_\_\_\_\_

\_\_\_\_\_

**Genetic Screening:**

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on your ethnicity. Are you: African-American  Yes  No

Ashkenazi Jewish  Yes  No      Mediterranean/Asian/French Canadian  Yes  No

**If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.**

**11. HISTORY OF FERTILITY THERAPY (Fill out, if applicable).**

Have you been treated for infertility previously?  YES  NO If yes, who was your physician? .....

What cause of infertility was diagnosed? .....

What medications have you taken for infertility? .....

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

- |  |                     |               |
|--|---------------------|---------------|
| <input type="checkbox"/> Semen Analysis    | When ____/____/____ | Results ..... |
| <input type="checkbox"/> Chromosomes       | When ____/____/____ | Results ..... |
| <input type="checkbox"/> Genetic screening | When ____/____/____ | Results ..... |
| <input type="checkbox"/> OTHER _____       |                     |               |

Have you ever undergone Artificial Insemination (IUI)  YES  NO or In Vitro Fertilization (IVF)?  YES  NO

If yes,  partner  donor sperm #IUI's \_\_\_\_ #IVF cycles \_\_\_\_

12. We, at FSMG, understand that infertility can place a significant burden on the respective couple. This stress can have a profound impact on the reproductive system. Given these facts and our emphasis on treating the whole person, we would like to know your experience with / willingness to try alternative therapies. These include, but are not limited to:

- Acupuncture (if so, which acupuncturist) \_\_\_\_\_  
Dates: + Current + Previous \_\_\_\_\_
- Herbal treatment \_\_\_\_\_  
Dates: + Current + Previous \_\_\_\_\_
- Massage \_\_\_\_\_  
Dates: + Current + Previous \_\_\_\_\_
- Psychological/group therapy \_\_\_\_\_  
Dates: + Current + Previous \_\_\_\_\_
- Yoga / biofeedback / stress reduction techniques \_\_\_\_\_  
Dates: + Current + Previous \_\_\_\_\_

**Welcome, we look forward to working with you. Please write down any specific concerns you want to review at your visit.**

**-The FSMG Team**