MALE MEDICAL HISTORY

KINDERWUNSCHZENTRUM
GOLDENES KREUZ

Name: **Surname:** **Date of Birth:**

Dear patient, filling out this questionnaire correctly and completely is very important because this allows us to estimate your situation faster during the consultation and to choose the best treatment strategy for you. Your assistance is greatly appreciated!

1. Do you have children or have you ever attained a pregnancy?

☐ No ☐ No, with my prior partner I also had an unfulfilled desire to have children.

☐ Yes, with my actual partner. Year of birth:
After fertility treatment? ☐ No ☐ Yes
☐ Yes, with my prior partner. Year of birth:
After fertility treatment? ☐ No ☐ Yes

2. Andrological diseases:

Question	No	Yes	Details
Have you ever had a vasectomy?	☐	☐	in (Month/Year)
If "Yes", have you ever had a vasectomy reversal?	☐	☐	in (Month/Year)
Do you have a malformation of the spermatic duct?	☐	☐	☐ Left ☐ Right
Did you suffer of undescended testis as a child?	☐	☐	☐ Left ☐ Right
Have you ever had an inflammation of the testis?	☐	☐	In (Month/Year)
Have you ever had an injury of the testicles	☐	☐	In (Month/Year)
Have you ever had a varicose vein on the testis?	☐	☐ ☐	☐ No surgery operation in (Month/Year)
Have you ever had cancer of the testis?	☐	☐ ☐	☐ No surgery operation in (Month/Year) ☐ Left ☐ Right
Do you or have you ever had problems having an erection?	☐	☐	

Notes:

3. Have you undergone any of the following examinations?

Important: If you have the results from any of the examinations, please send these!

Examination	No	Yes	Details (if known)	
Semen analysis	☐	☐	Last time in: (Month/Year)	
Urological examination	☐	☐	Last time in: (Month/Year)	
Check of the Prostate gland	☐	☐ was	☐ OK	☐ not OK
Chromosome mapping / Caryotyping	☐	☐ was	☐ OK	☐ not OK
Cystic fibrosis (CFTR gene test)	☐	☐ was	☐ Negative	☐ Positive
Biopsy of the testis	☐	☐	☐ Left ☐ Right In (Month/Year)	

Notes:

4. Do you or have you ever suffered from any of the following diseases? (check all that apply)

Disease	No	Yes	Details if known (e.g. name of the disease, since when)	Since	Therapy See *6
Allergy against medication:	☐	☐			☐ Yes*
Cancer / Tumors	☐	☐			☐ Yes*
Mumps	☐	☐	Were your testicles affected? ☐ Yes		
Diabetes	☐	☐	since treated with: Pills ☐ / Injections (Insulin) ☐		☐ Yes*
High blood pressure / Hypertonic disease	☐	☐	>160 ☐ below 160 ☐ below 140 ☐		☐ Yes*
Lung disease (Asthma, Bronchitis)	☐	☐			☐ Yes*
Neurological disease (e.g. Epilepsy, Vascular, Trauma, Tumor, Inflamation)	☐	☐			☐ Yes*
Kidney / Bladder disease (e.g. Insufficiency, Cysts, Tumors, Inflamation)	☐	☐			☐ Yes*
Heart disease (e.g. Infarction, rhythmic disorder, Insufficiency, deformed valves)	☐	☐			☐ Yes*
Liver disease (e.g. Hepatitis, Cirrhosis, Cysts)	☐	☐			☐ Yes*
Stomach or intestines (e.g. Inflammation, Ulcers, Immunological & Chronic diseases)	☐	☐			☐ Yes*
Thyroid gland diseases	☐	☐			☐ Yes*

Notes:

5. Do you have or have you ever had any of the following symptoms? (check all that apply)

Symptom	No	Yes	How often?	Due to Stress?	Since	Therapy See *6
Sleeping problems	☐	☐	Times / Week	☐ Yes*		☐ Yes*
Weakness	☐	☐	Times / Week	☐ Yes*		☐ Yes*
Frequent or/& Strong headaches / Migraines	☐	☐	Times / Week	☐ Yes*		☐ Yes*
Panic / Depressions	☐	☐	Times / Week	☐ Yes*		☐ Yes*
Extreme nervousness	☐	☐	Times / Week	☐ Yes*		☐ Yes*
Hair loss	☐	☐	Severe ☐ Head ☐ Body ☐			☐ Yes*
Acne	☐	☐	On the face ☐ a/o on the body ☐			☐ Yes*
Painful urination	☐	☐	☐ Often ☐ Blood in urine			☐ Yes*

Notes:

MALE MEDICAL HISTORY

KINDERWUNSCHZENTRUM
GOLDENES KREUZ

6*. If you take any medication regularly, please give details below:

Medication Name	Dose	Since	Why?

7. Have you ever had surgery of the abdomen and/or lower abdomen?

☐ None If Yes ☐ please use the following table to give details:

Year	Appendectomy (A), Laparoscopic surgery (L), Laparotomy (T)	Where (Hospital) and Why?
	☐ A ☐ L ☐ T	
	☐ A ☐ L ☐ T	
	☐ A ☐ L ☐ T	
	Other surgeries?	

Notes:

8. How often do you have sexual intercourse?

Usually times/week times/month

9. Your weight and height please: kg cm

10. Do you smoke or have you ever smoked?

☐ No, never ☐ I quit smoking months years ago
☐ Yes, I smoke cigarettes/day

11. Do you drink alcohol?

☐ Never ☐ Rarely ☐ Occasionally ☐ Regularly

12. Do you or have you ever consumed any drugs?

☐ Never ☐ Yes, in the past ☐ Yes, now:

13. Did or do any of your relatives suffer from the following? (Check all that apply):

Genetic diseases ☐ Yes* ☐ No Infertility: ☐ Yes* ☐ No

Cancer (> 2 close relatives) ☐ Yes* ☐ No Other:

* Details (who is affected and how severely):

14. What is your profession?

I am working as:

Are you exposed to any severe physical stress or chemical substances at your workplace?

☐ No ☐ Yes, I am exposed to: