

MALE MEDICAL HISTORY



Виена Ин Витро Център
Vienna In Vitro Center

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

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	<input type="checkbox"/>	<input type="checkbox"/>	Last time in: (Month/Year)
Urological examination	<input type="checkbox"/>	<input type="checkbox"/>	Last time in: (Month/Year)
Check of the Prostate gland	<input type="checkbox"/>	<input type="checkbox"/> was	<input type="checkbox"/> OK <input type="checkbox"/> not OK
Chromosome mapping / Caryotyping	<input type="checkbox"/>	<input type="checkbox"/> was	<input type="checkbox"/> OK <input type="checkbox"/> not OK
Cystic fibrosis (CFTR gene test)	<input type="checkbox"/>	<input type="checkbox"/> was	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
Biopsy of the testis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Left <input type="checkbox"/> Right In (Month/Year)

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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:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Cancer / Tumors	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Were your testicles affected? <input type="checkbox"/> Yes		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	since treated with: Pills <input type="checkbox"/> / Injections (Insulin) <input type="checkbox"/>		<input type="checkbox"/> Yes*
High blood pressure / Hypertonic disease	<input type="checkbox"/>	<input type="checkbox"/>	>160 <input type="checkbox"/> below 160 <input type="checkbox"/> below 140 <input type="checkbox"/>		<input type="checkbox"/> Yes*
Lung disease (Asthma, Bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Neurological disease (e.g. Epilepsy, Vascular, Trauma, Tumor, Inflammation)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Kidney / Bladder disease (e.g. Insufficiency, Cysts, Tumors, Inflammation)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Heart disease (e.g. Infarction, rhythmic disorder, Insufficiency, deformed valves)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Liver disease (e.g. Hepatitis, Cirrhosis, Cysts)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Stomach or intestines (e.g. Inflammation, Ulcers, Immunological & Chronic diseases)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Yes*
Thyroid gland diseases	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	Times / Week	<input type="checkbox"/> Yes*		<input type="checkbox"/> Yes*
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Times / Week	<input type="checkbox"/> Yes*		<input type="checkbox"/> Yes*
Frequent or/& Strong headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Times / Week	<input type="checkbox"/> Yes*		<input type="checkbox"/> Yes*
Panic / Depressions	<input type="checkbox"/>	<input type="checkbox"/>	Times / Week	<input type="checkbox"/> Yes*		<input type="checkbox"/> Yes*
Extreme nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Times / Week	<input type="checkbox"/> Yes*		<input type="checkbox"/> Yes*
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Severe <input type="checkbox"/> Head <input type="checkbox"/> Body <input type="checkbox"/>			<input type="checkbox"/> Yes*
Acne	<input type="checkbox"/>	<input type="checkbox"/>	On the face <input type="checkbox"/> a/o on the body <input type="checkbox"/>			<input type="checkbox"/> Yes*
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Often <input type="checkbox"/> Blood in urine			<input type="checkbox"/> Yes*

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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?
	<input type="checkbox"/> A <input type="checkbox"/> L <input type="checkbox"/> T	
	<input type="checkbox"/> A <input type="checkbox"/> L <input type="checkbox"/> T	
	<input type="checkbox"/> A <input type="checkbox"/> L <input type="checkbox"/> 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:

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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: