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Fertility Questionnaire for Men

General Information:

1. Name _____ Age _____
2. Spouse's Name _____ Age _____
3. Your Social Security Number ____-____-____
4. Occupation _____

Urologic History:

1. Do you have or have you ever had (check all that apply):
 - _____ Herpes
 - _____ Gonorrhea
 - _____ Chlamydia
 - _____ Trichomoniasis
 - _____ Nongonococcal Urethritis (NGU)
 - _____ Any sexually transmitted (Venereal) disease
 - _____ Any infection in your penis, testicles, epididymis, or Seminal vesicles
2. Did your mother take DES or any other hormones while pregnant with you?

_____	Yes	_____	No
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3. Have you ever fathered a child or caused a pregnancy?

_____	Yes	_____	No
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4. Have you ever had any problems with your penis or testicles?

_____	Yes	_____	No
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5. Have you ever had any surgery on your penis or testicles?

_____	Yes	_____	No
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6. Have you ever had a hernia repair?

_____	Yes	_____	No
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7. Have you ever had any injury to your penis or testicles?

_____	Yes	_____	No
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8. Is urination, ejaculation, or intercourse painful?

_____	Yes	_____	No
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9. Have you ever had difficulty or slowness in growing a beard or facial hair?

_____	Yes	_____	No
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10. Did you have mumps after age 12?

_____	Yes	_____	No
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11. Do you wear jockey shorts (tight underwear)?

_____	Yes	_____	No
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12. Have you ever been told you had a fertility problem or decreased sperm count?

_____	Yes	_____	No
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13. Do you ever have an orgasm without ejaculation during masturbation?

_____	Yes	_____	No
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Sexual History:**Yes No**

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|---|-------|-------|
| 1. Do you feel that you or your wife have a significant problem in achieving orgasm? | _____ | _____ |
| 2. Do you have difficulty in maintaining an erection? | _____ | _____ |
| 3. Do you have difficulty ejaculating in the vagina? | _____ | _____ |
| 4. Do you have problems with premature ejaculation? | _____ | _____ |
| 5. Do you masturbate more than once per week? | _____ | _____ |
| 6. Do you feel that you and/or your wife might benefit from some form of sexual counseling? | _____ | _____ |
| 7. Do you feel that infertility is putting a strain on your marital relationship? | _____ | _____ |

Medical History:

1. Do you have or have you ever had (check all that apply):
 - _____ Breast Discharge
 - _____ Breast Enlargement
 - _____ Liver Disease
 - _____ Neurological Problems
 - _____ Psychological Problems
 - _____ Tuberculosis
 - _____ Cancer (specify) _____

2. Have you ever been exposed to medicines, chemicals, or other substances that you think may have affected your fertility?
(Specify) _____

3. Do you have any medical conditions which you think your medical provider should be aware of?
(Specify) _____

4. Do you take any medicines on a frequent or regular basis?
(Specify) _____

Habits:**Yes No**

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|--|-------|-------|
| 1. Do you smoke cigarettes or chew tobacco? | _____ | _____ |
| 2. Do you drink wine or other alcoholic beverages on a daily or almost daily basis? | _____ | _____ |
| 3. In the past five years, have you used any nonprescription drugs (e.g., marijuana, cocaine, etc.)? | _____ | _____ |
| 4. Do you take herbal products or high doses of any vitamins? | _____ | _____ |

Family/Genetic History

Yes No

- | | | |
|---|-------|-------|
| 1. Has anyone in your family been born with a birth defect(s)? | _____ | _____ |
| 2. Is anyone in your family mentally impaired or delayed? | _____ | _____ |
| 3. Are there any inherited diseases in your family? | _____ | _____ |
| 4. Has a member of your family had any of the following:
albinism, hemophilia, Huntington's disease, cystic fibrosis,
muscular dystrophy, or hereditary anemia? | _____ | _____ |
| 5. Has a member of your immediate family had epilepsy or
psychiatric disorders requiring treatment? | _____ | _____ |
| 6. The risk of having a child with cystic fibrosis is 1 in 3300.
Would you like genetic testing to determine your risk status? | _____ | _____ |
| 7. Is there a history of two or more Lynch syndrome cancers in the
same person or on the same side of the family (colon, uterine,
ovarian, stomach, kidney/urinary tract, gall bladder, intestine,
pancreas, brain, or sebaceous adenoma)? | _____ | _____ |
| 8. Is there a family history of breast cancer before age 50? | _____ | _____ |