Date:_____

Patient MR #: _____

EVALUATION FORM
FOR MALE FACTOR SUBFERTILITY
UT ERLANGER MEN'S HEALTH

Name _____

Medical Record Number _____

Age _____

Date of Birth _____

Occupation _____

Religion _____

How did you hear about our Male Infertility Clinic? _____

Years attempting conception _____

Previous Conception Yes No

If yes, previous impregnation Date _____

If yes, previous impregnation number _____

Prior evaluation Yes No

If yes, prior test results _____

If yes, prior treatment and results _____

SEXUAL HISTORY

Erectile Difficulty Yes No

Ejaculatory Difficulty Yes No

Loss/change in libido (sex drive) Yes No

Frequency of intercourse/week _____

Frequency of intercourse @ovulation _____

Frequency of masturbation/month _____

Lubrication Use Yes No

If yes, what type _____

CHILDHOOD AND DEVELOPMENT

Age of onset of puberty _____

Testicular torsion/trauma Yes No

MEDICAL HISTORY

Heart Disease	Yes	No
Heart Murmur	Yes	No
Hypertension	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Hepatitis	Yes	No
Multiple Scierosis	Yes	No
Epilepsy	Yes	No
Neurologic Disease (other)	Yes	No
Cancer	Yes	No

If yes, type and treatment _____

Other _____

SURGICAL HISTORY (if yes, specific procedure and date)

Orchidopexy (surgical repair of undescended testicle)	Yes	No
Orchiectomy (surgical removal of testicle)	Yes	No

If yes, diagnosis _____

Bladder neck surgery	Yes	No
Hernia repair	Yes	No
Pelvic surgery	Yes	No
Scrotal surgery	Yes	No
Retroperitoneal surgery (involving abdominal organs)	Yes	No
Transurethral surgery	Yes	No

Other _____

INFECTIONS (if yes, when and how was it treated)

Gonorrhea	Yes	No
Chlamydia	Yes	No
Syphilis	Yes	No
Herpes	Yes	No
Mumps	Yes	No
Viral	Yes	No
Prostatitis	Yes	No
Urethritis	Yes	No
Cystitis (bladder infection)	Yes	No
Pyelonephritis (kidney infection)	Yes	No
Epididymitis/orchitis (testicle infection)	Yes	No

Other _____

MEDICATION/CHEMICAL/ENVIRONMENTAL EXPOSURE

Prescription medications Yes No

If yes, name and dosage _____

Drug Allergies Yes No

If yes, name of drug _____

Cimetidine (Tagamet) Yes No

Sulfasalazine/Asacol Yes No

Aspirin Yes No

Alcohol Yes No

If yes, how much and how often _____

Marijuana Yes No

If yes, how much and how often _____

Other drugs Yes No

If yes, how much and how often _____

Tobacco Yes No

If yes, how much and how often _____

Hot tubs Yes No

If yes, how much and how often _____

Anabolic steroids Yes No

Chemicals Yes No

Pesticides Yes No

Radiation Yes No

Thermal exposure Yes No

Are you currently using, or have you ever used, complimentary therapies to enhance fertility potential? (i.e., acupuncture, Chinese medicine, herbal remedies) Yes No

Please list: _____

FAMILY HISTORY (if yes, who in family affected)

Cystic fibrosis Yes No

Other infertility Yes No

Heart disease Yes No

Diabetes Yes No

Cancer Yes No

Genetic disease Yes No

REVIEW OF SYSTEMS

Have you had any of the following:

Constitutional – weight change, weakness, fever, fatigue, chills	Yes	No
Eyes – change in vision, pain, redness, excessive tearing, double vision	Yes	No
ENT – change in hearing, frequent colds, nosebleeds, sore throats	Yes	No
Cardiovascular – high blood pressure, murmurs, chest pain	Yes	No
Respiratory – cough, shortness of breath, asthma, bronchitis	Yes	No
Gastrointestinal – difficulty swallowing, heartburn, nausea, vomiting	Yes	No
Genitourinary – hemauris, frequency, urgency, discharge, lumps	Yes	No
Musculoskeletal – muscle or joint pain, stiffness, arthritis	Yes	No
Skin/Breasts – rashes, itching, lumps, sores, color change	Yes	No
Neurological – dizziness, fainting, blackouts, seizures, weakness	Yes	No
Psychiatric – nervousness, tension, mood change including depression	Yes	No
Endocrine – diabetes, thyroid disease, excessive sweating or thirst	Yes	No
Hematological/Lymphatic – anemia, easy bruising	Yes	No
Allergic/Immunologic – immunizations, allergies, HIV testing	Yes	No

If you answered YES o any of the above please explain them below: _____

_____

_____

_____

FEMALE INFORMATION

Age _____

Date of Birth _____

Occupation _____

Age of onset menses _____

Menstrual cycle: every _____ days Flow: Heavy Medium Light

Length of menses (# of days) _____

Cycles regular	Yes	No
Smoker	Yes	No

If yes, how many packs per day and for how long? _____

Previous pregnancy	Yes	No

If yes, number, year, and number of deliveries _____

Infertility evaluation	Yes	No

If yes, what tests and results _____

PHYSICAL EXAM

Temperature _____
Blood pressure _____
Pulse _____
Height _____
Weight _____

HEENT normal		Yes	No
If no, describe abnormalities _____			
Gynecomastia		Yes	No
Lymphadenopathy		Yes	No
Lungs clear		Yes	No
Heart regular rate/rhythm		Yes	No
Abdomen			
Tender		Yes	No
Masses (liver/spleen)		Yes	No
Scars		Yes	No
Hernia		Yes	No
Penis			
Circumcised		Yes	No
Meatus normal		Yes	No
Plaques/curvature		Yes	No
Testes			
Descended		Yes	No
Number		_____	
Size (vol. or cm		_____	
Masses		Yes	No
Tender		Yes	No
Epididymis			
Present		Yes	No
Indurated/tender		Yes	No
Spermatic cord			
Vas present		Yes	No
Varicocele		Yes	No
If yes, how big	Small	Medium	Large
Rectal			
Prostate size		_____	
EPS		Yes	No
Seminal vesicles palpable		Yes	No
Extremities intact		Yes	No
Neurologic exam intact		Yes	No