University Reproductive Associates

Patient Questionnaire Date: _____

Please take a few minutes to answer these questions as completely as possible. Thank you

Name: _____ Occupation: _____

Partnerôs Name: _____ Occupation: _____

Doctor referred you here: _____

Medical/Surgical History:

Allergies: Ǐ Denies Ǐ Latex Ǐ Contrast Dye Ǐ Food _____

Ǐ Medications: _____

Ǐ Other: _____

Explain Reaction: _____

Do you have any medical conditions or problems? (if yes, please explain)

_____

_____

Have you had any surgery? (operation/year)

_____

_____

Do you take any medications, vitamins, or herbal supplements? (please list)

_____

_____

Do you smoke cigarettes? (packs per day x number of years) _____

Do you drink alcohol? (number of drinks in an average week) _____

Do you use any street drugs? (marijuana, cocaine, etc.) _____

Family History (Parents, Grandparents, Siblings, Aunts, Uncles, etc.)

Breast Cancer	no___	yes___	(who/age it occurred)_____
Ovarian Cancer	no___	yes___	(who/age it occurred)_____
Uterine Cancer	no___	yes___	(who/age it occurred)_____
Colon Cancer	no___	yes___	(who/age it occurred)_____
Birth Defects	no___	yes___	(who/age it occurred)_____
Osteoporosis	no___	yes___	(who/age it occurred)_____
Diabetes	no___	yes___	(who/age it occurred)_____
High Blood Pressure	no___	yes___	(who/age it occurred)_____

Other family diseases _____

_____

MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

ð Have you been evaluated by a urologist? Ï Yes Ï No
ð Have you previously conceived with another woman? Ï Yes: How many times? ___ Ï No: Birth control used? Yes____ No____
ð Have you had a semen analysis? Ï Yes Ï No
ð Do you have difficulty with erections? Ï Yes Ï No
ð Do you have retrograde ejaculation of sperm into the bladder? Ï Yes Ï No
ð Have you had any of the following sexually transmitted diseases or pelvic infections?
Ï Yes (check all the apply) Ï No
Ï Chlamydia ï date ____ Ï Gonarrhea ï date _____ Ï Herpes ï date ____ Ï Genital warts/HPV ï date _____
Ï Syphilis ï date _____ Ï HIV/AIDS ï date _____ Ï Hepatitis ï date ____ Ï Other _____
ð Have you had a history of undescended testicles? Ï Yes ï One side_____ Both _____ Ï No
ð Do you have scrotal or testicular pain? Ï Yes Ï No
ð Did you have mumps after puberty? Ï Yes Ï No
ð Have you had prior injury to your testicles requiring hospitalization? Ï Yes Ï No

ð Have you been diagnosed with any of the following diseases?
Ï Diabetes Mellitus ï Yes___ No___ Ï Cancer ï Yes___ No___
Ï Multiple Sclerosis ï Yes___ No___ Ï Other neurologic problems - Yes___ No___
Ï Prostatic infections ï Yes___ No__ Ï Urinary infections ï Yes___ No____
Ï High Blood Pressure ï Yes___ No___ If yes, any medications? _____

ð Have you had any fever in the last 3 months? Ï Yes Ï No
ð Have you had a vasectomy? Ï Yes (date_____) Ï No
If yes, have you had a vasectomy reversal? Ï Yes (date_____) Ï No
ð Have you had surgery for varicocele repair? Ï Yes Ï No
ð Have you had hernia surgery? Ï Yes Ï No
ð Did you undergo any bladder or penis surgery as a child? Ï Yes Ï No
ð Are you exposed to prolonged heat in the workplace? Ï Yes Ï No
ð Are you exposed to any radiation or harmful chemicals in the workplace? Ï Yes Ï No
ð Have you had chemotherapy for cancer? Ï Yes Ï No
ð Are you allergic to any medications? Ï No Ï Yes (Please list and describe reactions)_____
_____
_____

List your current medications: _____

List any current medical problem(s): _____

ð How many caffeinated beverages do you drink per day? _____ Ï None
ð Do you smoke cigarettes? Ï No Ï Yes How many/day? ____ How many years? _____ Ï Quit ï when? _____
ð Do you drink alcohol? Ï No Ï Yes
Ï Beer - # per week ___ Ï Wine - # per week ___ Ï Liquor - # per week ___
ð Do you use marijuana, cocaine, or any other similar drug? Ï No Ï Yes (describe_____) ð Do you use herbal medicines/vitamins or health food store supplements? Ï No Ï Yes (describe_____)
ð Are you aware of any radiation/toxic materials exposure? Ï Yes Ï No

ð Do you use hot tubs regularly? Ï Yes Ï No
ð Did your mother take DES during pregnancy to prevent miscarriage? Ï Yes Ï No Ï Donôt know
ð Have any of your immediate family members had difficulty conceiving a child? Ï Yes Ï No
If yes, please describe _____

Physician Notes (for office use only)
_____
_____
_____

Disorders in Your Family

		Relationship to You		
ð Cystic Fibrosis	Ï Yes	_____	Ï No	Ï Donôt Know
ð Tay-Sachs disease	Ï Yes	_____	Ï No	Ï Donôt Know
ð Canavan disease	Ï Yes	_____	Ï No	Ï Donôt Know

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What is your Ancestry?
Ï African ï American
Ï American Indian/Native American
Ï Ashkenazi Jewish
Ï Cajun/French Canadian
Ï Caucasian
Ï Eastern European
Ï Hispanic/Caribbean
Ï Northern European
Ï Southern European
Ï Other (specify_____)

ð Bloom syndrome	Ï Yes	_____	Ï No	Ï Donôt Know
ð Gaucher disease	Ï Yes	_____	Ï No	Ï Donôt Know
ð Nieman-Pick disease	Ï Yes	_____	Ï No	Ï Donôt Know
ð Fanconi Anemia	Ï Yes	_____	Ï No	Ï Donôt Know
ð Familial Dysautonia	Ï Yes	_____	Ï No	Ï Donôt Know
ð Muscular Dysautonia	Ï Yes	_____	Ï No	Ï Donôt Know
ð Neurologic (brain/spine)	Ï Yes	_____	Ï No	Ï Donôt Know
ð Neural Tube Defects	Ï Yes	_____	Ï No	Ï Donôt Know
ð Bone/Skeletal Defects	Ï Yes	_____	Ï No	Ï Donôt Know
ð Dwarfism	Ï Yes	_____	Ï No	Ï Donôt Know
ð Developmental delay	Ï Yes	_____	Ï No	Ï Donôt Know
ð Learning problems	Ï Yes	_____	Ï No	Ï Donôt Know
ð Polycystic kidney disease	Ï Yes	_____	Ï No	Ï Donôt Know
ð Heart defect from birth	Ï Yes	_____	Ï No	Ï Donôt Know
ð Down syndrome	Ï Yes	_____	Ï No	Ï Donôt Know
ð Other chromosome defects	Ï Yes	_____	Ï No	Ï Donôt Know
ð Marfan syndrome	Ï Yes	_____	Ï No	Ï Donôt Know
ð Hemophilia	Ï Yes	_____	Ï No	Ï Donôt Know
ð Sickle Cell Anemia	Ï Yes	_____	Ï No	Ï Donôt Know
ð Thalassemia	Ï Yes	_____	Ï No	Ï Donôt Know
ð Galactosemia	Ï Yes	_____	Ï No	Ï Donôt Know
ð Deafness/Blindness	Ï Yes	_____	Ï No	Ï Donôt Know
ð Color Blindess	Ï Yes	_____	Ï No	Ï Donôt Know
ð Hemochromatosis	Ï Yes	_____	Ï No	Ï Donôt Know
Ï None of the above	Ï Other (Specify_____			

SPOUSE/MALE PARTNER'S SIGNATURE _____ DATE_____

I Confirm that I have reviewed the information above.

PHYSICIAN'S SIGNATURE_____DATE_____