

LANSING INSTITUTE OF UROLOGY, P.C.

INFERTILITY QUESTIONNAIRE

<i>Work History</i>		
Occupation		
Employer		
Are you ever exposed to any of the following?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemicals of solvents and their fumes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Temperature extremes (cold or hot)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
X-rays or radio-isotopes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your occupation stressful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Sexual Activity History</i>		
How frequently do you have intercourse?		
Do you obtain an erection easily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever ejaculate prior to penetration for intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is intercourse ever painful to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is intercourse ever painful for your partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is her vagina ever so tight that you cannot penetrate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use any form of lubrication for intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a prior child(ren)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever impregnated someone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How long have you been trying to have children?		

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INFERTILITY QUESTIONNAIRE (*continued*)

<i>Medical History</i>		
Have you ever had blood in your semen (during ejaculation)? If yes, when?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had an infection of your urinary tract?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, when?		
Have you ever had mumps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, did it affect your testicles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a venereal infection (VD or gonorrhea)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you have undescended testicles at birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you have hernia, scrotal, or testicular surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been on prolonged bed rest?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, for what and when?		
Have you ever had trauma (injury) to your testicles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a white, green, or yellow discharge from the end of your penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you frequently take hot baths, saunas, or steam baths?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear jockey shorts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you ever receive medication for cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you ever receive radiation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No