Patient History Assessment Form
Male Fertility Screening Questionnaire

1. Personal details

Name			
Address			
Date of Birth			
Telephone			
Email			
Height in cm		Weight in Kg	

2. Relationship status

2.1 Are you	☐ Single	☐ In a relationship

If you are in a relationship, please complete below as appropriate

Relationship	Yes (please tick)	Length of relationship in Years and Months	
Heterosexual	☐	Years	Months
Same Sex	☐	Years	Months
Other	☐	Years	Months

2.2 Please state your partner's name and their date of birth	
Name	
Date of birth (dd/mm/yy)	/ /

3. Previous pregnancies

3.1 Have you ever had a pregnancy with any partner?	☐ Yes	☐ No

If yes, please provide details of these pregnancies below, other than those that may have been achieved with your current partner (Details of these pregnancies will have been provided by your partner in her questionnaire).

	Total number	Year/s
Livebirth		
Miscarriage		
Ectopic pregnancy		
Termination of pregnancy		
Stillbirth		

3.2 Do you have any adopted children?	☐ Yes	☐ No
3.3 *If yes;* was your child/children adopted with your current partner?	☐ Yes	☐ No

4. Previous fertility treatment

4.1 Have you ever had previous fertility investigations, e.g. semen analysis?	☐ Yes	☐ No

If yes, please give details

Investigation	Result	Year	Fertility Service Provider

4.2 Have you ever had fertility treatment?	☐ Yes	☐ No

If yes, please provide details of this treatment below, **other than** treatment with your current partner (Details of these treatments will have been provided by your partner in her questionnaire).

4.3 Have you ever had fertility treatment involving IUI?	☐ Yes	☐ No
4.4 Have you ever had IVF / ICSI?	☐ Yes	☐ No
4.5 Do you have any stored material remaining, e.g. embryos, eggs or sperm in storage?	☐ Yes	☐ No

5. Sexual history

5.1 Have you any difficulties with?	Erections	☐ Yes	☐ No
	Ejaculation (release of sperm from your penis)	☐ Yes	☐ No
	Sex/Intercourse	☐ Yes	☐ No
If yes, please provide details			

5.2 Have you ever had a sexually transmitted infection (STI)?	☐ Yes	☐ No

If yes; which infection and what treatment did you receive?

6. Medical / surgical history

6.1 Please detail any significant medical conditions or treatment, e.g diabetes, heart disease, cancer treatment.

6.2 Please detail any surgeries or difficulties with your testicles, scrotum, penis or hernias. Please provide surgery dates.

6.3 Have you previously had bloods taken for;

Hepatitis	☐ Yes	☐ No	If yes please indicate result;	
HIV	☐ Yes	☐ No	If yes please indicate result;	

7. Current medications

7.1 Please list your current medications (inclusive of non-prescribed medication, e.g. vitamins, supplements)

8. Family history

8.1 Please provide details of any hereditary disorders, birth defects or fertility challenges in your family.

9. General health

9.1 Do you smoke	☐ Yes	☐ No
If yes, how many per day?		
9.2 Do you vape?	☐ Yes	☐ No
9.3 Do you currently use recreational drugs?	☐ Yes	☐ No
9.4 Do you drink alcohol?	☐ Yes	☐ No
If yes, how many standard drinks do you have on average every week? *1 standard drink = ½ pint of beer, 1 small glass of wine or 1 single measure of spirits*		

10. Any other information you think is relevant