Herts & Essex Fertility Centre

Male Partner Health Questionnaire

NAME..... **D.O.B**.....

RELATIONSHIP HISTORY

How long have you been living together..... Years

Have you fathered any children before with: Previous Partner Yes/No
Present Partner Yes/No

If yes, quote number and age.....

How many times do you have intercourse per week .... Week

MEDICAL/SURGICAL HISTORY

Have you had a sperm test before? Yes/No
If yes, was it normal? .....

Have you had any of the following?

Hormone Tests Yes/No

Vasectomy Yes/No

Vasectomy Reversal Yes/No

If yes, please give approx date of operation.....

Have you had any semen test since the reversal and was sperm found?
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Undescended testicles Yes/No

Torsion of the testicles Yes/No

Any operation on the testicles? Yes/No

Hydrocele (cyst) in the scrotum Yes/No

Chemotherapy/Radiotherapy	Yes/No
Sexually transmitted disease (gonorrhoea, syphilis, chlamydia)	Yes/No
Hernia operation in your groin	Yes/No
Trauma to the testicles, causing swelling	Yes/No
Mumps causing swelling/pain to the testicles	Yes/No
Difficulty producing sperm	Yes/No
Psychosexual (difficulty with erection or ejaculation)	Yes/No
Cardiovascular e.g. heart disease, raised blood pressure	Yes/No
Respiratory e.g. asthma, bronchitis, tuberculosis	Yes/No
Diabetes	Yes/No
MRSA (Including close contact)	Yes/No
Have you had any recent illness within the last 3 months	Yes/No

If yes to any of the above, please provide details:

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DRUG HISTORY

Are you on any regular medications? If yes, please list:

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Do you have any allergy to drugs? Yes/No
If yes, please give details

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Do you have any other allergies e.g. Latex, Elastoplast?

Yes/No

If yes, please give details

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GENERAL HEALTH

What is your height .....Metres or ..... Ft .....Inches

What is your weight ..... Kg or .....stone .....Lbs

BMI = ... (to be calculated by clinic)

SOCIAL HISTORY

Do you smoke? Yes/No
If yes how many cigarettes per day? .....

Do you drink? Yes/No
If yes how many units per week? .....

(1 Unit of Alcohol = ½ Pint of Beer or 1 small glass of wine)

Do you take recreational drug? .....Yes/No

PLEASE BRING ANY REPORT OR RESULTS WITH YOU WHEN YOU ATTEND THE CONSULTATION

I confirm that the above information is an accurate record of my medical history from the date stated below.

Signed: ..... Date: .....