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**PregnaClinic Fertility Medical Questionnaire Form**

**(MALE)**

**Section 1 - GENERAL INFORMATION**

**1.1 ALL ABOUT YOURSELF**

FULL NAME: DATE OF BRITH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARTIAL STATUS:

Partner Name: Partner DOB:

Height: Weight: Race:

Occupation:

**1.2 CONTACT DETAILS** ADDRESS

Phone (day):

Phone (night):

E-mail:

1.3 Do you have children? Yes No

If yes, please specify how many, how old and gender of each below

**For each of the children, please specify whether your current partner is she their biological mother. If not please state below.**

**SECTION 2 - Fertility History**

2.1 How long have you and your present partner been trying to conceive?

2.2 Have you ever been infertile with a past partner? If so, How long?

2.3 Has your current partner ever being pregnant with another partner.

If yes , how many pregnancies?

And how many went to full term

2.4 Is there a history of fertility problems in your close family for example with your parents, brothers, sisters or

uncles?

If so, give a brief explanation and which member(s) of family it was

3.5 Have you received any fertility treatment? Yes No

If so, what types of fertility therapy have you received in the past and give brief details on its outcome below

**Section 3 – Sexual acTIVITY & Medical history**

3.1 How often do you have intercourse?

3.2 In the past 6 months do you notice any change in your desire to have sex or sex drive?

3.3 Have you had any problems with erections?

3.4 Do you masturbate Yes No

If yes how often

3.5 Please tell us of any medical conditions you had or currently suffering from and brief description of

Medication taken

3.6 Do any family members have significant health problems or inherited diseases, including fertility related

If so, who and briefly explain

**Section 4 – SEXUAL HEALTH**

4.1 Have you had more than one partner in the last year? Yes No I’ve had one partner

4.2 Have you ever been tested for a sexually transmitted disease? Yes No

4.3 If yes, Have been diagnosed with any sexual transmitted disease (if yes, circle all that apply):

Chlamydia , Gonorrhoea, HIV , Syphilis , Other

4.4 If yes, when was the last time you had one of these diseases? \_\_\_\_\_\_\_\_\_\_\_ month/\_\_\_\_\_\_\_\_\_\_\_\_year 8.

4.5 Have you ever gotten the hepatitis B vaccine (3 injections)?

Yes (all 3 doses) Yes (less than 3 doses) No I do not know

**SECTION 5- SOCIAL HISTORY**

5.1 Current or Recent Employer/Position

Occupation

5.2 Do you drink alcohol?

If yes, please specify number of drinks per week

5.3 Do you smoke?

If yes, please specify number of cigarettes per day

please specify number of years smoking

5.4 Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc.)?

If yes, please specify

5.5 Do you have a special exercise program?

Number of hours per week

5.6 Are you on a special diet?

Type