



# Male Fertility Questionnaire

How long have you and your partner been trying to conceive? \_\_\_\_\_

How is your sexual energy? \_\_\_\_ Low \_\_\_\_ Normal \_\_\_\_ High

Do you have undescended testes? \_\_\_\_ Yes \_\_\_\_ No

Have you ever been diagnosed with a varicocele? \_\_\_\_ Yes \_\_\_\_ No

Have you had any urologic surgeries? \_\_\_\_ Yes \_\_\_\_ No

Have you had a vasectomy reversed? \_\_\_\_ Yes \_\_\_\_ No

Have you experienced difficulty maintaining an erection? \_\_\_\_ Yes \_\_\_\_ No

Have you experienced difficulty ejaculating? \_\_\_\_ Yes \_\_\_\_ No

Have you been exposed to any known environmental toxins or hormones? \_\_\_\_ Yes \_\_\_\_ No

Do you smoke? \_\_\_\_ Yes \_\_\_\_ No

Do you eat soy products? \_\_\_\_ Yes \_\_\_\_ No

Do you eat lots of processed snack foods? \_\_\_\_ Yes \_\_\_\_ No

Have you experienced penile discharge? \_\_\_\_ Yes \_\_\_\_ No

Do you regularly experience nocturnal emissions? \_\_\_\_ Yes \_\_\_\_ No

Have you had a fertility workup? \_\_\_\_ Yes \_\_\_\_ No

If yes, what was your sperm count? \_\_\_\_ Below normal \_\_\_\_ Normal

Number \_\_\_\_\_

What was the sperm motility? \_\_\_\_ Below normal \_\_\_\_ Normal

Specifics \_\_\_\_\_

What was your sperm morphology? \_\_\_\_ Below normal \_\_\_\_ Normal

Specifics \_\_\_\_\_

Are you taking any prescription medications? \_\_\_\_ Yes \_\_\_\_ No

If so, what are they?

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Please list any non-prescription medications you are currently taking, including herbs, supplements, and over-the-counter medications:

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