



Infertility Treatment
Endometriosis
Laparoscopic Surgery
Reproductive Microsurgery

Confidential Patient Information - Male

By answering the following questions as accurately as possible, you help us get a better understanding of the problems that may influence your fertility. Take your time and read all the questions carefully. Give the completed questionnaire to your doctor.

Surname and given name: _____ First Name: _____

Specific questions for the male partner:

Life style Weight (kg): _____ Height (cm): _____
Have you lost or gained a lot of weight recently? Yes No
Do you smoke? Yes No How many cigarettes per day? _____
Do you drink alcohol? Regularly Rarely Never
Do you come in contact with harmful substances in your work place: Yes No

Have you ever been treated for one of the following illnesses?
diabetes: Yes No
thyroid disease: Yes No
liver or kidney disease: Yes No
chronic lung disease: Yes No

Do you know of people in your family who have an inherited condition? Yes No

Have you ever had an operation? Yes No

- If yes, have you ever had a:
operation on one or both testicles: Yes No
vasectomy: Yes No
operation on the bladder: Yes No
prostate operation: Yes No
operation on the penis: Yes No
inguinal hernia repair: Yes No
operation on your spinal cord: Yes No

Have you ever had mumps? Yes No At what age? _____

Have you ever experienced severe pain in one or both testicles? Yes No

Have you ever been treated for an undescended testicle? Yes No

Have you ever been treated for a urinary infection? Yes No

Have you ever had problems with erection or ejaculation? Yes No

If you have had other partners, was one of them ever pregnant? Yes No

Are you on regular medication and if yes which? _____

Do you have any allergies (medications, food ...)? _____

Personal remarks: _____

I declare the above information to be complete and correct.

Signature: _____ Date: _____

Other rooms