



INSTRUCTIONS:

- 1. The following infertility questionnaire should only take about ten minutes to complete.**
- 2. If you cannot answer a question, simply leave it blank.**
- 3. DO NOT complete the gray-shaded areas.**
- 4. Please bring the completed form to your first visit, or fax it to us prior to your first visit.**

NAME: _____ AGE: _____

PARTNER'S NAME: _____ PARTNER'S AGE: _____

REFERRING PHYSICIAN: _____ REFERRING DR. PHONE: () -

TODAY'S DATE: / /

MEDICAL HISTORY

Have you been treated for any of the following conditions?..... yes no

diabetes chronic respiratory disease inflammatory bowel disease

tuberculosis mumps orchitis seizure disorder

Have you ever used any of the following medications? yes no

prednisone cortisone sulfasalazine nitrofurantoin

cyclosporine cimetidine spironolactone niridazole

procordia ketoconazole dilantin digoxin

Have you had any of the following operations?..... yes no

hernia repair varicocelectomy orchiopexy urethral stricture

prostatectomy vasectomy hypospadias bladder neck

hydrocelectomy testis biopsy

Have you ever had any of the following conditions?..... yes no

chlamydia gonorrhea syphilis herpes

tuberculosis

Have you ever been treated for cancer? yes no

Are you taking medications now? If so, please list the medication and dosage below..... yes no

Are you allergic to medications? If so, please list the medication (s) below..... yes no

Have you had a high fever in the past 6 months? yes no

Have you ever had a urinary tract infection?..... yes no

Have you ever had epididymitis?..... yes no

Have you ever had prostatitis?..... yes no

Have you ever had testicular torsion?..... yes no

Have you ever had a serious injury to one or both testes?..... yes no

Have you ever been treated for undescended testis?

MEDICATIONS: _____ ALLERGIES: _____ NKDA



Sarah K. Girardi, M.D.

FERTILITY

How long have you and your partner been trying to achieve a pregnancy? _____ months
Have you ever achieved a pregnancy with your current partner?
Has your partner been evaluated by a gynecologist?
If so, was the evaluation normal? (If no, please specify below)
Have you ever achieved a pregnancy with another partner?
Has your current partner ever achieved a pregnancy with another partner?

NOTES: _____

FAMILY HISTORY

How many brothers do you have?
Are any of your brothers infertile?
Do any of your family members have cystic fibrosis?
Did your mother use DES during her pregnancy?
How many sisters do you have?
Are any of your sisters infertile?

ENVIRONMENTAL AND OCCUPATIONAL HISTORY

Do you smoke tobacco?
Are you a former smoker?
Have you been exposed to second hand smoke?
Do you use any of the following currently?
Do you use alcohol on a regular basis?
Have you ever used pesticides on a regular basis?
Have you been exposed to toxic chemicals on a regular basis?
Have you been exposed to heavy metals on a regular basis?
Have you been exposed to radiation (X-rays) on a regular basis?
Have you been exposed to industrial solvents on a regular basis?

SEXUAL FUNCTION

What is the average frequency of intercourse?
Do you know when your partner is ovulating?
Do you know how to time intercourse to her cycle?
Are you able to maintain erections long enough to ejaculate inside your partner?
Do you sometimes ejaculate too early?
Are you able to maintain erections firm enough to penetrate your partner?
Do you require manual stimulation to maintain erections for successful intercourse?



Sarah K. Girardi, M.D.

PHYSICAL EXAMINATION

Height: _____ Weight: _____ BP: _____

General appearance: Normal Abnormal

Virilization: Normal Abnormal

Gynecomastia: Absent Present Tanner Stage: _____

GENERAL EXAMINATION

NECK	<input type="checkbox"/> Normal <input type="checkbox"/> supple <input type="checkbox"/> thyromegaly	<input type="checkbox"/> Abnormal <input type="checkbox"/> adenopathy <input type="checkbox"/> other	FLANK	<input type="checkbox"/> Normal <input type="checkbox"/> tender	<input type="checkbox"/> Abnormal <input type="checkbox"/> nontender
LUNGS	<input type="checkbox"/> Normal <input type="checkbox"/> CTAP <input type="checkbox"/> rhonchi	<input type="checkbox"/> Abnormal <input type="checkbox"/> rales <input type="checkbox"/> wheeze	ABD	<input type="checkbox"/> Normal <input type="checkbox"/> scars <input type="checkbox"/> rebound <input type="checkbox"/> organomegaly	<input type="checkbox"/> Abnormal <input type="checkbox"/> tender <input type="checkbox"/> guarding <input type="checkbox"/> mass
COR	<input type="checkbox"/> Normal <input type="checkbox"/> RRR <input type="checkbox"/> murmur <input type="checkbox"/> rub	<input type="checkbox"/> Abnormal <input type="checkbox"/> regularly irregular <input type="checkbox"/> gallop	EXT	<input type="checkbox"/> Normal <input type="checkbox"/> clubbing <input type="checkbox"/> edema	<input type="checkbox"/> Abnormal <input type="checkbox"/> cyanosis <input type="checkbox"/> tenderness

GU EXAMINATION

PENIS	<input type="checkbox"/> Normal <input type="checkbox"/> circumcised <input type="checkbox"/> terminal meatus <input type="checkbox"/> skin lesions	<input type="checkbox"/> Abnormal <input type="checkbox"/> uncircumcised <input type="checkbox"/> hypospadias <input type="checkbox"/> plaques	LEFT EPIDIDYMISS	<input type="checkbox"/> Normal <input type="checkbox"/> present <input type="checkbox"/> flat <input type="checkbox"/> tender	<input type="checkbox"/> Abnormal <input type="checkbox"/> absent <input type="checkbox"/> full <input type="checkbox"/> indurated						
SCROTUM	<input type="checkbox"/> Normal <input type="checkbox"/> hydrocele <input type="checkbox"/> skin lesion <input type="checkbox"/> folliculitis	<input type="checkbox"/> Abnormal <input type="checkbox"/> spermatocele <input type="checkbox"/> angiokeratoses	RIGHT EPIDIDYMISS	<input type="checkbox"/> Normal <input type="checkbox"/> present <input type="checkbox"/> flat <input type="checkbox"/> tender	<input type="checkbox"/> Abnormal <input type="checkbox"/> absent <input type="checkbox"/> full <input type="checkbox"/> indurated						
LEFT TESTIS	<input type="checkbox"/> Normal <input type="checkbox"/> _____ cc <input type="checkbox"/> firm <input type="checkbox"/> mass <input type="checkbox"/> no varicocele	<input type="checkbox"/> Abnormal <input type="checkbox"/> soft <input type="checkbox"/> tender <input type="checkbox"/> varicocele Grade I II III	LEFT VAS	<input type="checkbox"/> Normal <input type="checkbox"/> present <input type="checkbox"/> granuloma	<input type="checkbox"/> Abnormal <input type="checkbox"/> absent <input type="checkbox"/> gap						
RIGHT TESTIS	<input type="checkbox"/> Normal <input type="checkbox"/> _____ cc <input type="checkbox"/> firm <input type="checkbox"/> mass <input type="checkbox"/> no varicocele	<input type="checkbox"/> Abnormal <input type="checkbox"/> soft <input type="checkbox"/> tender <input type="checkbox"/> varicocele Grade I II III	RIGHT VAS	<input type="checkbox"/> Normal <input type="checkbox"/> present <input type="checkbox"/> granuloma	<input type="checkbox"/> Abnormal <input type="checkbox"/> absent <input type="checkbox"/> gap						
RECTAL EXAMINATION	<input type="checkbox"/> Normal anal sphincter tone BCR prostate	<input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> Normal <input type="checkbox"/> irregular <input type="checkbox"/> tender _____ gm	<input type="checkbox"/> Abnormal <input type="checkbox"/> Abnormal <input type="checkbox"/> Abnormal <input type="checkbox"/> indurated <input type="checkbox"/> cyst	<table border="1"> <tr> <td>RIGHT TESTIS</td> <td>LEFT TESTIS</td> <td>PROSTATE</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>		RIGHT TESTIS	LEFT TESTIS	PROSTATE			
RIGHT TESTIS	LEFT TESTIS	PROSTATE									



IMPRESSION

- primary infertility
 - secondary infertility
 - obstructive
 - non-obstructive
 - mixed
 - varicocele 456.4
 - hypogonadism 257.2
 - congenital absence of the vas 752.8
 - cryptorchidism 752.51
 - hypogonadism, hypogonadotropic 253.4
 - genital duct stricture 608.85
 - retractile testis 752.52
 - erectile dysfunction, organic 607.84
 - epididymitis 604.9
 - atrophy of testis 608.83
 - erectile dysfunction, psychogenic 302.72
 - epididymitis, obstructive 608.85
 - idiopathic oligospermia 606.1
 - elective sterilization V25.2
 - idiopathic azoospermia 606.0
 - pyospermia
- ICD9 CODE: _____

PLAN:

TESTING:

- hormone profile (T FSH LH PRL E2)
- semen analysis
- genetic studies
- microY
- karyotype
- semen culture
- cystic fibrosis testing
- antisperm antibodies
- renal ultrasound
- post-ejaculate urine analysis
- scrotal ultrasound
- expressed prostatic secretion
- liver function studies

RETURN OFFICE VISIT:

- phone call only
- two weeks
- three months
- six months
- one year

MEDICATIONS:

- none
- Clomid 25 mg po q day
- Teslac 50 mg po bid
- Arimidex 1 mg po q day
- Other _____

- schedule left microsurgical varicocelectomy
- schedule bilateral microsurgical varicocelectomy
- schedule bilateral microsurgical testis biopsy
- schedule bilateral microsurgical vasovasostomy
- schedule bilateral vasoepidymostomy