



Fertility Questionnaire – Men

Please fill out the following fields. If any question is unclear, simply mark it with a question mark. Thank you!

Name	_____	Address	_____
First Name	_____		_____
Date of Birth	_____	Phone	_____
Occupation	_____	Email	_____

Are you married to each other?

☐ No ☐ Yes, since _____ (Year)

Pregnancies

Have you already achieved a pregnancy?

☐ No

☐ Yes, with current partner, in: _____ (Year) After fertility treatment? No ☐ Yes ☐

☐ Yes, with previous partner, in: _____ (Year) After fertility treatment? No ☐ Yes ☐

Were you already involuntarily childless with a previous partner?

☐ No ☐ Yes

Urological History

Have you already been examined by a doctor specialising in urology or andrology?

☐ No ☐ Yes, last in: _____ (Year) What was the result? ☐ Normal ☐ Abnormal

Have you already been prescribed medication by your urologist/andrologist?

☐ No ☐ Yes, the following: _____

Have you undergone sterilization?

☐ No ☐ Yes, in: _____ (Year)

If yes, were you later refertilized?

☐ No ☐ Yes, in: _____ (Year)

Have you ever had a sperm analysis (spermiogram)?

☐ No ☐ Yes, last in: _____ (Year) What was the result? ☐ Normal ☐ Abnormal

Do you suffer from erectile dysfunction?

☐ No ☐ Yes

Have you ever had a testicular injury?

☐ No ☐ Yes, in: _____ (Year)

What treatment was given? _____

Did you have undescended testicles as a child?

☐ No ☐ Yes, left ☐ Yes, right

If yes, which therapy was applied?

☐ None ☐ Hormone Therapy ☐ Surgery

Did you have an inflammation of the testicles?

☐ No ☐ Yes, in: _____ (Year)

If yes, what treatment was given (e.g., surgery)? _____

Did you have a testicular tumor?

☐ No ☐ Yes, left ☐ Yes, right

If yes, when? _____ (Year)

What treatment was given? _____

Do you or did you have varicose veins on your testicles (varicocele)?

☐ No ☐ Yes ☐ If yes, with the following treatment (e.g., surgery): _____

General Medical History

Do you have or have you had one or more of the following illnesses or conditions?

☐ Thyroid diseases	since _____ (Year)	☐ Kidney diseases	since _____ (Year)
☐ Mumps	since _____ (Year)	☐ Liver diseases	since _____ (Year)
☐ Diabetes	since _____ (Year)	☐ Cancer	Type? _____ since _____ (Year)
☐ Cardiovascular diseases	since _____ (Year)	☐ Mental illness	since _____ (Year)
☐ Thrombosis/Embolism	since _____ (Year)	☐ Headache/Migraine	since _____ (Year)
☐ Blood clotting disorders	since _____ (Year)	☐ Hereditary diseases	since _____ (Year)
☐ Epilepsy	since _____ (Year)	☐ Other	Which? _____ since _____ (Year)
☐ Asthma/Chronic bronchitis	since _____ (Year)		_____ since _____ (Year)
☐ Gastrointestinal diseases	since _____ (Year)		_____ since _____ (Year)

Are you taking medication?

☐ No ☐ Yes, the following: _____

How much do you weigh and how tall are you?

Weight (kg) _____ Height (cm) _____ BMI _____

Have you already undergone surgery?

☐ No ☐ Yes, the following: _____ in _____ (Year)
_____ in _____ (Year)
_____ in _____ (Year)

Do you have any allergies (e.g., to medications, antibiotics)?

☐ No ☐ Yes, the following: _____

Do you drink alcohol?

☐ Never ☐ Rarely ☐ Occasionally ☐ Regularly

Do you smoke?

☐ No ☐ Yes, _____ cigarettes/day

Do you consume other substances (drugs or doping)?

☐ No ☐ Yes, the following: _____

Are there any serious illnesses in your family (e.g., hereditary diseases, cancer, involuntary infertility)?

☐ No ☐ Yes, the following: _____

Have you had an inpatient hospital stay of more than 3 days in the last 12 months?

☐ No ☐ Yes, due to: _____

Do you have or have you ever had chronic bacterial colonization (e.g., MRSA)?

☐ No ☐ Yes

Who is your general practitioner?

Who is your urologist/andrologist?

Additional Information
