

J. MICHAEL PUTMAN, M.D. & ASSOCIATES
ADVANCED GYNECOLOGIC ENDOSCOPY

3900 Junius Street, Ste 610
Dallas, Texas 75246
(214) 823-2692
(214) 887-8244 FAX

FERTILITY QUESTIONNAIRE - PARTNER

Name: _____ Age: _____ Date: _____

A. GENERAL INFORMATION

- 1) How long have you been married?
- 2) How long have you been seeking a pregnancy?
- 3) Is this your first marriage?
- 4) Do you have children from this marriage?
If yes, how many children? Adopted _____ Biological _____
- 5) Do you have children from a previous marriage(s) or relationship?
If yes, how many children? Adopted _____ Biological _____

B. MEDICAL/SURGICAL

- 1) Have you ever had surgery?
If yes, Procedure Date Place
- 2) Have you recently lost or gained over 20 pounds?
- 3) Do you exercise regularly?
If yes, how often and what type?
- 4) Do you follow any special dietary regimen?
- 5) Do you use or have you used:
 - () Prescription drugs or medications?
If yes, please list:
 - () Non-prescription drugs or medications?
If yes, please list:
 - () Herbal supplements or alternative medicine? If so, please list:
 - () Marijuana or other drugs?
 - () Tobacco products?
What? _____ How much? _____

() Alcoholic beverages?

What?

How much?

Do you have or have you ever had:

- | | | |
|--------------------------------|---------------------------|---------------------------------|
| () Anemia | () Epilepsy Seizures | () Liver Problems |
| () Appendicitis | () Excessive Sweating | () Measles |
| () Arthritis | () Gall Bladder Problems | () Mumps |
| () Blood Product Transfusions | () Gonorrhea | () Poor Sense of Smell |
| () Breast Discharge | () Headache | () Rheumatic Fever |
| () Bronchitis | () Heart Disease | () Intolerance to Heat or Cold |
| () Cancer | () Hepatitis | () Thyroid Problems |
| () Chlamydia | () Herpes | () Ulcer(s) |
| () Colitis | () High Blood Pressure | () Problems with Urination |
| () Color Blindness | () Impotency | () Urinary Tract Infection |
| () Diabetes | () Immunizations | () Urethritis |
| () Dizziness | | |

C. PREVIOUS FERTILITY EVALUATION AND TREATMENT

1) Have you had:

- () Semen Analysis
- () Sperm Antibody Assay
- () Mucous Penetration Assay
- () Hamster Egg Penetration Assay
- () Testicular Biopsy
- () Vasogram

1) Have you previously received fertility medication?

If yes, please list name and date:

2) Have you had a hernia repair?

If yes, where and when?

3) Have you had a varicocele repair?

If yes, where and when?

4) Do you wear briefs or boxer shorts?

5) Do you spend any amount of time in a sauna or hot tub more than 2 or 3 times a year?