

Questionnaire for Male patient ver. 1.1

Date: 20 ____/____/____

Name: _____ Age: _____ DOB: ____/____/____

Height: _____ cm Weight: _____ Kg Occupation: _____

<About your wife> Age: _____ # of Pregnancies: _____ # Miscarriages: _____ # Deliveries: _____

Your emergency contact (mobile)#: _____

1. Purpose of your visit today

- (1) Consultation and/or testing for infertility
 (2) My wife had infertility tests here and it was recommended that I also have the tests
 (3) I tested at another hospital and it was recommended that I had a detailed examination
 (4) Other (_____)

2. Trying for a baby for: about _____ year(s) and _____ month(s)**3. Marital status**

- (1) Married: at (_____) years of age in ____/____/____, # of children: _____
 (2) Divorced and remarried: Divorced in ____/____/____, Remarried in ____/____/____
 # of children with your ex-wife: _____, # of children with your current wife: _____
 (3) Engaged (4) Single
 ◆ For those who have child(ren): Age of your child(ren) _____
 Conceived (by): (Naturally / Timing method / Artificial Insemination / IVF / ICSI) **Please circle**

4. Have you ever had Semen analysis or Hormone test?

- (1) Yes, in ____/____/____ (2) No
 ↳ The result came back Normal/Abnormal (Specify _____)

5. Do you smoke?

- (1) Yes (since I was _____ year of age, _____ cigarette a day) (2) No
 (3) Quit smoking for (_____ month(s)/year(s), had been smoking _____ cigarette a day)

6. Do you drink alcohol?

- (1) Yes (Everyday / _____ days a week / Occasionally) (2) No

7. Have you had a health checkup (annual checkup or complete health exam.) in the past year?

- (1) Yes in ____/____/____
 ↳ Result: (i) Normal (ii) advised to have Guidance (iii) advised to have a detailed exam/treatment
 (2) Had a checkup more than a year ago in ____/____/____ (3) No, I've never had it before.

8. Do you have or have you had any diseases for which you had a detailed exam and/or treatment at other hospitals?

- (1) No (2) Yes (Name of disease _____) since I was _____ years of age

9. Have you ever had allergic reaction or developed hives to medicine and/or food?

- (1) Yes (Name of medicine/food _____)
 (2) No

10. Have you had high fever or poor health in the past 3 months?

- (1) Yes (Name of disease _____) (2) No

< Please turn over >

11. Have you ever had Mumps (Epidemic parotitis) before?

(1) Yes (at _____ years of age) (2) No (3) Not sure

↳ Were your testes swollen at that time? (i) Yes (ii) No (iii) Not sure

12. Have you had an operation for undescended testis (cryptorchidism) or groin (inguinal) hernia?

(1) Yes (at _____ years of age) (2) No (3) Not sure

13. Have you had an operation for testis, seminal duct, or prostate other than those above?

(1) Yes (at _____ years of age, ^{Name of Operation} _____)

(2) No (3) Not sure

14. Have you had Chlamydia, Gonorrhea or inflammation of urethra, epididymis or prostate?

(1) Yes (at ^{age} _____, Treated?: Yes / No) (2) No (3) Not sure

15. Have you hit your testes hard or have you broken backbone or pelvis?

(1) Yes (^{Diagnosis} _____ at ^{age} _____) (2) No

16. Do you take any medicine or supplement regularly (more than once a month)?

(1) Yes (^{Name} _____ since around ^{yyyy/mm/} _____)

(2) No

17. Have you ever had empyema (sinus problem), bronchial ectasia, or chronic bronchitis?

(1) Yes (at _____ years of age) (2) No (3) Not sure

18. Have you ever had radiation therapy?

(1) Yes (at _____ years of age) (2) No (3) Not sure

19. Have you ever had anticancer drug therapy?

(1) Yes (at _____ years of age) (2) No (3) Not sure

20. Do you shave every day?

(1) Yes (2) No, I shave sometimes (about once in _____ days)

21. Do you have any concerns about sexual function or anything you'd like to consult about?

(1) Yes: No sex drive / Erectile dysfunction (ED) / Problems achieving penetration
Problems achieving intravaginal ejaculation / Problems achieving ejaculation
You felt like you ejaculated but no semen came
Other: _____

(2) No

22. <About your wife> Has she ever had infertility testing or treatment?

(1) Yes, she is/was visiting Reproduction Center at Sanno Hospital. (Sanno ID: _____)

(2) Yes, she is/was visiting other hospital. (from around ^{yyyy/mm/} _____ to ^{yyyy/mm/} _____)

Test result: Normal / Abnormal (^{Specify} _____)

Previous treatment: Timing method / Artificial insemination / IVF / ICSI

Please describe your comments and request - such as what you'd prefer to do/not to do - freely.

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Thank you for your cooperation. Please present this sheet on your consultation.