# Health Appraisal Questionnaire
# Male Fertility

Name: _____ DOB: _____

Address: _____

_____

Phone: _____ Mob: _____Email:_____

Your Signature: _____

**Please read each question below carefully and thoroughly and provide a detailed and truthful answer. Please complete this questionnaire & return it to us <u>as soon as possible</u> with a copy of your Comprehensive Semen Test Results obtained in the last 3 months.**

*Note: All information is regarded as strictly confidential and governed under the code of ethics.*

**Medical History:**

1. Have you ever had serial blood work done for any of the following (please circle):

   Karyotyping Hormone assay Thyroid function HIV

   Full blood analysis Fasting glucose Cholesterol

   Hepatitis C STIs Cystic Fibrosis Screening

   If you circled any of the above, when was the testing carried out, what were the results? _____

   _____

2. Do you have/have you suffered from any of the following medically diagnosed conditions (please circle):

   High blood pressure High cholesterol Diabetes An STI

Hernia Appendicitis HBP Vasectomy

Testicular issues Vasectomy reversal Other _____

_____

If you circled any of the above, please provide details: _____

_____

3. Have you had any medical investigations done (including physical check ups, testicular ultrasounds, surgery, biopsy, TESA)? Y / N

   Please provide details of what, when and any findings: _____

   _____

**General History:**

4. How long have you been trying to conceive? _____
5. What other methods, if any, have you tried to assist you to conceive:

   Natural methods:

   Temperature charting? Y / N

   Other _____

   Assisted Fertility (please circle if any applicable):

   IVF IUI ICSI Chlomid Cycle FT

   If you circled any of the above

   How many cycles? _____

   When did you begin the treatment/cycles? _____

   When was your most recent treatment/cycle? _____

   Any other relevant details _____

6. Have you had any pelvic or abdominal surgery or procedures done? Y / N

7. Are you taking any medication at all whatsoever? Please be specific and include any vitamins and herbal supplements. _____

_____

8. How many times per week are you currently having sex? _____
9. Do you feel that you are having sex as regularly as you should be? If not, please explain why. _____

_____

10. How is your libido (please circle) non-existent low average high
11. Do you have any bladder issues such as frequent urination, pain on urination, excessive nocturnal urination? Y / N
12. If yes, please describe: _____
13. Are there any known issues with sperm count, motility, morphology etc? _____

_____

14. Have you had a recent Comprehensive Semen Analysis? Y / N

    If yes, where was the test conducted (circle): a pathology lab fertility clinic

    When was the test done (circle): last 3 months last 6 months 6 months+

    **Diet**

15. Please complete the table on the following page including a detailed description of what you would eat at each meal on a typical day:

| | |
|---|---|
| **Breakfast** | |
| **Morning Tea** | |
| **Lunch** | |

| | |
|---|---|
| **Afternoon Tea** | |
| **Dinner** | |
| **Dessert** | |
| *Any* other<br><br>snacks | |
| **Approximate water intake plus other beverages** | |

16. How many standard glasses of alcohol do you drink per week? _____

17. Do you drink alcohol daily or only on weekends? _____

18. How many cups of tea/coffee do you drink per day? _____

19. Do you drink any caffeinated soft drinks? _____

**Appetite / Digestion**

20. How is your appetite (circle): Low Average High

21. How is your digestion (circle): Good Fluctuates Bad

22. Do you get any sugar cravings? Y / N If yes, when? _____

23. Do you get any of the following (circle): Bloating Burping

Wind Heartburn Nausea Other _____

If you circled any of the above how often and when? _____

24. Do you often skip meals? _____

**Bowels**

25. How many times per day do you move your bowels? _____

26. Are your motions (circle): Loose Normal Hard Alternating

27. Do you suffer from either lose bowels or constipation often? _____

_____

28. Are your bowel habits effected by stress? Y / N

**Emotions**

29. Please tick any of the following emotions if you feel that they would describe you:

| | | |
|---|---|---|
| ☐ Worry a lot | ☐ Quick to anger | ☐ Often irritable |
| ☐ Sometimes feel depressed | ☐ Feel resentful | ☐ Feel frustrated |
| ☐ Sad | ☐ Fearful in general | ☐ Think a lot |
| ☐ Stressed, hard to relax | ☐ Anxious | ☐ Panicky |
| ☐ 'Fuzzy' in the head | ☐ Burnt out/ tired | |

☐ Other _____

**Sleep**

30. Do you sleep well? Y / N

31. Do you have a medically diagnosed sleep condition? Y / N _____

32. Do you snore? Y / N

33. Do you wake feeling refreshed? Y / N

34. Do you find it hard to get to sleep? Y / N

35. Do you have vivid dreams? Y / N

36. Do you wake a lot during the night? Y / N If yes, how many times? _____

37. Do you experience nocturnal urination? Y / N

If yes, how many times per night? _____

**Miscellaneous**

38. Do you smoke (includes social smoking)? Y / N If yes, how often? _____

39. Do you currently or have you ever used recreational drugs? Y / N

If yes, when and what (please be specific) _____

40. Do you suffer from the following (please circle): Headaches Migraines

Back pain Stiff/Sore neck Stiff/sore shoulders

Any other conditions not mentioned above: _____