



**Questionnaire for the man**

Surname: ..... First name: ..... Date of birth: .....

Address: .....

Telephone Nr. Private: ..... Mobile: ..... Business: .....

Medical Insurance ..... Occupation: .....

Urologist ..... Email address: .....

Are you married to your partner?  yes  no Height:..... Weight:.....

**1. When did your pubic and underarm hair start growing?** at ..... years of age

**2. When did your voice break?** at ..... years of age

**3. Is your beard growth?**  sparse  average  strong

**4. Have you noticed a reduction in your energy and physical activity?**  
 no  yes since.....

**5. Have you noticed a decrease in your sexual performance/ability (libido) ?**  
 no  yes, since.....

**6. Do you experience problems having sexual intercourse {e.g. physical separation from partner, discomfort or pain, physical difficulties or differences of attitude with your partner} which you think could be a reason for your childlessness?**  
 no  yes .....

**7. Do you have any children of your own?**  no  yes  
if yes:  with present partner  with other partner

**8. Have you had a semen analysis (sperm test)?**  no  yes  
if yes: when where result  
.....

**9. Have you been treated for reduced fertility/ low sperm count?**  no  yes  
if yes: when where type of therapy / medication  
.....

**10. Have you had a physical examination of the genitals by a urologist, or a hormonal blood test?**  
 no  yes (please bring results with you)

**11. Have you had any of the following illnesses or conditions?**  no

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Thyroid disorder           | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Adrenal gland disease |
| <input type="checkbox"/> Thrombosis/Embolism        | <input type="checkbox"/> Migraine                  | <input type="checkbox"/> Kidney disease        |
| <input type="checkbox"/> Cardiovascular disease     | <input type="checkbox"/> Epileptic fits            | <input type="checkbox"/> Liver disease         |
| <input type="checkbox"/> Hypertension               |  |  |
| <input type="checkbox"/> Varicose veins             | <input type="checkbox"/> Cancer/ Tumours           | <input type="checkbox"/> Mental disorders      |
| <input type="checkbox"/> Asthma/ Chronic bronchitis | <input type="checkbox"/> Gastro-intestinal illness | <input type="checkbox"/> Infectious diseases   |
- Other: .....

**12. Have you previously had problems or operations in the genital region?**

- |   |  |                               |                                     |            |
|---|--|-------------------------------|-------------------------------------|------------|
| <input type="checkbox"/> Inflammation of testes | <input type="checkbox"/> right                       | <input type="checkbox"/> left | <input type="checkbox"/> both sides | when.....  |
| <input type="checkbox"/> Mumps                  | <input type="checkbox"/> right                       | <input type="checkbox"/> left | <input type="checkbox"/> both sides | when ..... |
| <input type="checkbox"/> Varicose veins         | <input type="checkbox"/> right                       | <input type="checkbox"/> left | <input type="checkbox"/> both sides | when ..... |
| <input type="checkbox"/> Testicular injury      | <input type="checkbox"/> right                       | <input type="checkbox"/> left | <input type="checkbox"/> both sides | when ..... |
| <input type="checkbox"/> Hernia operation       | <input type="checkbox"/> right                       | <input type="checkbox"/> left | <input type="checkbox"/> both sides | when ..... |
| <br>  |  |                               |                                     |            |
| <input type="checkbox"/> Undescended testicle   | <input type="checkbox"/> right                       | <input type="checkbox"/> left | <input type="checkbox"/> both sides | when ..... |
|   | <input type="checkbox"/> Hormone injection treatment |                               |                                     | when ..... |
|   | <input type="checkbox"/> Operation                   |                               |                                     | when ..... |
| <br>  |  |                               |                                     |            |
| <input type="checkbox"/> Other .....            | <input type="checkbox"/> right                       | <input type="checkbox"/> left | <input type="checkbox"/> both sides | when ..... |

**13. Do you take medication regularly?**  no

if yes, which? ..... what for?.....  
what for?.....

**14. Are you allergic to any medication or substances?**  no

yes, to .....

**15. Were you or are you exposed to any of the following (at work or at home)**

- |  |  |
|--|--|
| <input type="checkbox"/> Noise   | <input type="checkbox"/> Dust, Gas or other air pollutants       |
| <input type="checkbox"/> Solvents (Benzene Toluene Glycol ether)                       | <input type="checkbox"/> Pesticides, Insecticides (DDT, Lindane) |
| <input type="checkbox"/> Preservatives for leather, wood or textile                    | <input type="checkbox"/> Disinfecting agents (Borax, Boric acid) |
| <input type="checkbox"/> Heavy metals (Lead, mercury, Cadmium, Copper, Pewter, Silver) |  |

**16. Do you smoke?**  no  1-5 Cig/day  5-15 Cig/day  more, approx /day

**17. Do you drink alcohol?**  never  occasionally  regularly

**18. Have any of the following conditions been diagnosed in a blood relative in your family?**  no

- |   |                                      |                                 |
|---|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Thrombosis   | <input type="checkbox"/> Infertility | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Inherited diseases ( e.g. cystic fibrosis, Muscular dystrophy) |                                      |                                 |
| <input type="checkbox"/> Other  |                                      |                                 |

**19. Are you inoculated against hepatitis B?**  no if yes, when last?.....

**20. I agree forwarding of my diagnostic records to attending physicians**

- yes  no date, signature.....

**Comments:** .....  
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