Male Screening Questionnaire (Fertility)

Forms
Administration AF1.21

Merrion Fertility Clinic

Name		DOB (dd/mm/yyyy)								
Address										

When did you start trying to conceive?	

Previous children/paternities (including with other partners)

Previous Fertility Treatment Details
Have you ever had fertility treatment elsewhere? ☐ Yes ☐ No If Yes, please give brief details and bring any paperwork you may have to your consultation

Medical History	
(Include surgery/operations, childhood problems and medical conditions including mumps or any testicular injuries)	
Current medications	
Allergies to medications	

Family History
(Include history of serious hereditary disorders, birth defects and/or any multiple births)

Lifestyle			
Cigarettes per day		Average weekly alcohol intake (units) *(I unit = ½ pint beer, 1 small glass wine)*	
Average weekly exercise undertaken			
Do you have any significant stresses in your life? ☐ Yes ☐ No If Yes, please provide details			

Is there any other information you think we should know e.g. Religious/Ethical concerns? ☐ Yes ☐ No If Yes, please provide details

Signed _____ Date _____