

Male Screening Questionnaire (Fertility)



Forms
Administration AF1.21

Name		DOB (dd/mm/yyyy)	
Address			

When did you start trying to conceive?	
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Previous children/paternities (including with other partners)

Previous Fertility Treatment Details
Have you ever had fertility treatment or fertility investigations elsewhere? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please give brief details and forward any paperwork you may have prior to your Doctor consultation

Sexual History
Have you ever had any difficulties with erections/ejaculation/intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a sexually transmitted infection? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

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Lifestyle			
Cigarettes per day		Average weekly alcohol intake (units) <i>(1 unit = ½ pint beer, 1 small glass wine)</i>	
Average weekly exercise undertaken			
Do you have any significant stresses in your life? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, please provide details			

Is there any other information you think we should know e.g. Religious/Ethical concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please provide details

Zika and Pregnancy
Have you visited a Zika infected country in the last 6 months or have you any plans to? <input type="checkbox"/> Yes <input type="checkbox"/> No
See link for information https://merrionfertility.ie/zika-virus/