Total Wellness Centre
10 Roden Place
Toronto, On M5R 1P5
www.totalwellnesscentre.ca
Tel: 416 532 9094
Fax: 416 642 2532

Male Fertility Questionnaire

This questionnaire is strictly confidential and will be shared only with your practitioners.

How long have you and your partner been trying to conceive? _____

How would you define your sexual energy? ___ Below normal ___ Normal

Do you masturbate? ___ Yes ___ No
If yes, how often: _____

Have you had a recent physical exam? ___ Yes ___ No
If yes, when? _____
mm/dd/yy

Do you or did you have an undescended testicle? ___ Yes ___ No

Have you ever been diagnosed with a Varicocele? ___ Yes ___ No

Have you been diagnosed with small or soft testis? ___ Yes ___ No

Have you ever had urologic surgeries? ___ Yes ___ No
If yes, detail:

_____

_____

Have you experienced erectile dysfunction? ___ Yes ___ No

Have you experienced difficulty ejaculating? ___ Yes ___ No

Have you had exposure to environmental toxins or hormones? ___ Yes ___ No

Do you regularly experience nocturnal emissions? ___ Yes ___ No

Do you have high cholesterol? ___ Yes ___ No

Have you experienced a high fever in the last 6 months? ___ Yes ___ No

Do you currently have a prostate condition? ___ Yes ___ No

Have you experienced any penile discharge? ___ Yes ___ No
If yes, what colour: _____

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Do you or have you ever had urinary tract infections? ___ Yes ___ No

Do you experience high frequency of urination? ___ Yes ___ No

Do you ever experience burning when urinating? ___ Yes ___ No

Do you have urgency to urinate? ___ Yes ___ No

Do you ever have pain when urinating? ___ Yes ___ No

Do you have dribbling in between urination? ___ Yes ___ No

Have you ever contracted STDs? ___ Yes ___ No
If yes, which STD: _____

Have you ever taken testosterone supplements/drugs? ___ Yes ___ No

Have your testosterone levels been checked? ___ Yes ___ No
If yes: ___ Normal ___ Low

Have you been checked for blockage of your reproductive tract? ___ Yes ___ No

Have you had a fertility workup? ___ Yes ___ No
If no, please discuss this with your MD
If yes, what was your sperm count? _____ million
What was the sperm motility? _____ %
What was the sperm morphology? _____ %
What was the volume? _____ ml
How many days of abstinence? _____

Has the sperm DNA fragmentation been checked? ___ Yes ___ No
If yes, what is the DNA Sperm Fragmentation %? _____

If you have impregnated a female partner in the past, please describe if full term, miscarriage, or therapeutic abortion (include the number of pregnancies, your age at the time, and any complications): _____

_____

_____

_____

_____