Date of visit Year Month Day

Men's Medical Questionnaire

***Please fill this out accurately.**

(You)	Name (Family, Given)	Date of birth: Year Month Day (Age:) Occupation:
	Cell phone Number	E-mail address on your cell phone
(Partner)	Name (Family, Given)	Date of birth Year Month Day (Age:) Occupation:
	Cell phone Number	E-mail address on your cell phone
Address	(zip code)	Home phone E-mail address(PC)

***We use your personal information for administrative purposes only.**
***Would you mind if we mention the name of our clinic when we contact you on the phone? (Yes・No)**
***Have you attended our clinic's seminar? (Attended/ Year Month , Not attended)**

1 **Blood Type A・B・O・AB** RH(+)・(−) **Height cm Weight kg BMI kg/m²**

2 **Specific treatment you would like:**

Medical evaluation ・ Fertility check ・ Male infertility treatment ・ IUI ・ IVF-ET ・ other ( )

3 **Marital status** Age at Marriage ____years old (Date: Year____Month____Day____)

Divorce (Year Month) Second Marriage (Year Month)

Engaged ・ Common-law marriage ・ Single

4 **Length of sterility**: How long have you and your partner been trying to achieve pregnancy?

(_____years_____months)

Length of contraceptive use

None ・ Yes (From Year/Month / to / : ____years ____months)

5 **Has the cause of your infertility been diagnosed?**

(Diagnosis :)

6 **Have you ever had a semen examination?**

Never

Yes (Clinic name:)

(Result: Normal・Few sperm・Not active・No sperm・Other:)

7 **Have you ever received radiation therapy or anti-cancer therapy?**

Never ・ Yes (Details:)

8 **Have you ever had mumps?**

Never ・ Yes (Age: years old: Testicles were: swollen・not swollen) ・ unknown

9 **Have you ever undergone testicular biopsy, TESE (Testicular sperm extraction), chromosome banding or genetic testing?**

Never ・ Yes (Age: years old, Details:)

10 **Have you ever undergone surgery for any of the following?**

Undescended testicles No・Yes (age) (Left ・Right)	**Inguinal hernia** No ・ Yes (age) (Left ・Right)
Hydrocele testicle No ・ Yes (age) (Left ・Right)	**Vasectomy** No・Yes (age)
Testicular injury No ・ Yes (age) (Left ・Right)	
Other surgery around testis, scrotum or penis? No ・ Yes (Left ・ Right) (Details:)	

11 **Are you taking any medication or supplements regularly?** No・Yes (Name:)

12 **Have you had any adverse reactions to a blood test, examination, injection, medicine, or treatment?**

No・Yes (Details:)

13 **Do you have any allergies ?**

No ・ Yes (Details:)

14 **Do you have asthma ?**

No ・ Yes, in the past ・ Yes, currently (Details:)

15 **Do you have glaucoma ?** No・Yes (Details:)

16 **Have you ever been seriously ill or injured or had major surgery or diabetes?**

Please give all the details from birth up until now, including current medical issues and past abnormal test results

No・ Yes (Details:)

Spinal cord injury (Age: Cause:)

17 **Have you ever had any infectious disease?**

No ・ Yes (hepatitis B・C, syphilis, AIDS/HIV, other:)

18 **Have you or anyone in your family ever been diagnosed with tuberculosis?**

No ・ Yes (who?)

19 **Does anyone in your family have sterility problems or any hereditary disease?**

No ・ Yes (who?)

20 **Do you smoke?** No · Yes (/ day) Started at the age of ( )

21 **Do you drink alcohol?** No · Yes (every day · sometimes)
Beer · Wine · Liquor (how much a day:)

22 **Intercourse** (about times a month)

23 **Please answer the following questions;**

① **Have you ever had a sexually transmitted disease such as chlamydia or gonorrhea?**
(No · Yes)

② **Do you shave every day?** (No · Yes; frequency:)

③ **Can you smell scents?** (No · Yes)

④ **How is your ejaculation?**
1. Cannot ejaculate and have no orgasm
2. Cannot ejaculate but have orgasm
3. Can ejaculate with a small amount of semen
4. Can ejaculate with a normal amount of semen

⑤ **How is your sexual desire?**
1. Non-existent
2. Very little
3. Slightly decreased
4. Normal

⑥ **How long does it take you to ejaculate?**
1. I cannot ejaculate
2. Very long
3. Long
4. Normal
5. Somewhat short
6. Very short
7. I ejaculate immediately

⑦ **How is your orgasm?**
1. Non-existent
2. Drastically decreased
3. Slightly decreased
4. Satisfactory

⑧ **How is your erection during intercourse?**
1. Penis gets big but not stiff
2. Penis gets stiff but not enough to insert
3. Penis gets stiff enough to insert but not completely hard.
4. Penis gets completely hard and stiff

24 **Has your partner been receiving treatments at other clinic?**

Yes, currently ・ Yes, in the past ・ Never

Details of the treatment (　　)

25 **Has your partner come to our clinic?** Never ・ Yes

26 **Has your partner experienced miscarriages or stillbirths?** Never ・ Yes

(Details:　　)

27 **How did you learn about our clinic?** (Check the boxes below)

- □ Introduced by another doctor (Clinic:　　Doctor:　　)
- □ Introduced by someone (Name:　　Relationship:　　)
- □ Phone book
- □ TV
- □ Public signboards (where:　　)
- □ Newspaper (Article about our clinic・Advertisement for our clinic)
- □ Magazines (Akachan ga hoshii, Jineko, other :　　)
- □ Website (Searched by keywords・Site for fertility treatment・i-town page)
- □ Ninkatsu seminar (attended ・ saw the article)
- □ Recommended by my partner
- □ Because my partner has been to this clinic
- □ Other (　　)