

MALE FERTILITY INTAKE

Name _____ Date of Birth _____

How long trying to conceive? _____ Any children? _____

Have you had a fertility workup? _____

Sperm: Mobility _____ Morphology _____ Quantity _____ Other issues affecting fertility _____

Any sexually transmitted diseases? _____

Sexual desire - High Medium Low Very low

Do you exercise regularly? _____

If so, what do you like to do for exercise and how often?

Do you have a good outlet for stress? If so, what?

Do you feel your stress level is high? _____

What medications are you taking?

What vitamins or supplements are you taking?

Do you eat a well balanced diet? Always Sometimes Occasionally Never

Do you eat breakfast? Always Sometimes Occasionally Never

Do you sleep well? _____ How many hours on average a night? _____

Do you have nightsweats? _____ Do you smoke? _____

How often? _____

Do you drink alcohol? _____ How often? _____

Do you drink coffee / caffeine drinks? _____ How often? _____

Do you use recreational drugs? _____ What? _____

How often? _____

Do you regularly go in hotubs or saunas? _____

Do you have a well balanced diet? _____

Any Issues with Sexual Performance (ie Getting or maintaining an erection, premature ejaculation etc)? _____

Any fear or concerns around becoming a father? _____

Any other concerns related to fertility? _____

Any other concerns related to your health in general? _____