Dr. Myuran Ponnam-Palam
FERTILITY SPECIALIST

Confidential Fertility Patient Medical Questionnaire – Male

Answering the below questions accurately as possible will help us understand any issues that may be impacting your fertility. Please take your time answering all questions and return to reception.

Surname: _____ First/Middle Name: _____

Date of Birth: ____/____/____ Height (CM): _____ Weight (KG): _____

(Please tick)

Do you smoke? ☐Yes ☐No How many cigarettes per day? _____

Do you drink alcohol? ☐Regularly ☐Rarely ☐Never

Do you use recreational drugs? ☐Yes ☐No If yes, please specify: _____

Does anyone in your family have an inherited medical condition? ☐Yes ☐No

If yes, please specify: _____

Have you ever been treated for any of the following diseases? **(Please tick)**

☐Diabetes ☐Thyroid Disease ☐Chronic Lung Disease ☐Liver or Kidney Disease

Have you ever had an operation? ☐Yes ☐No If yes please specify: _____

_____

Have you ever had mumps? ☐Yes ☐No

Have you ever experienced severe pain in testicles? ☐Yes ☐No

Have you ever been treated for undescended testicle? ☐Yes ☐No

Have you ever had a urinary infection? ☐Yes ☐No

Have you ever had problems with erection or ejaculation? ☐Yes ☐No

Have you ever used anabolic steroids? ☐Yes ☐No

Have you ever gotten your previous partner/s pregnant? ☐Yes ☐No

If yes, how many children do you have from your previous relationship/s? _____

Are you currently on any medication? ☐Yes ☐No If yes, please specify: _____

_____

Do you have any allergies? ☐Yes ☐No If yes, please specify: _____

_____

Personal Remarks: _____

_____

I declare the above information to be complete and correct

Signature: _____ Date: _____/_____/_____