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FAMILY MEDICINE

Infertility – Male Factor

Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Height _____

Address _____ City _____ State _____

Email _____ Phone _____

Do you smoke? **Y \ N**

Health concerns you'd like to address:

□ Weight loss / gain Target weight: _____

□ Increased fitness □ Optimal health □ Decrease GI symptoms

□ Increase athletic performance □ Increased energy □ Improve biochemical (lab) values

□ Decrease disease risk □ Improved sleep □ Improve blood pressure

□ Other _____

Do you suffer from any of the following conditions?

□ Liver cirrhosis □ Cystic fibrosis □ Kidney disease

□ Swallowing problems □ HIV positive

Please specific the type of work you do _____ How many days a week _____

Do you exercise? _____ If so, what kind?

1. Type of Exercise _____ How many times a week _____ for how long _____
2. Type of Exercise _____ How many times a week _____ for how long _____
3. Type of Exercise _____ How many times a week _____ for how long _____

Do you suffer from the following gastrointestinal conditions?

□ Crohn's disease □ Colitis □ Diarrhea □ H. Pylori

□ Constipation □ Candidiasis □ IBS □ Gas and bloating

Do you have food allergies, restrictions, or sensitivities? _____

_____

Did you go through any of the following surgeries?

□ Stomach surgery □ Small intestine surgery □ Gall bladder surgery

□ Colon surgery □ Heart surgery □ Catheterization

□ Bariatric bypass □ Bariatric sleeve □ Bariatric gastric band

Do you take any nutritional supplements or vitamins? _____ If so, which ones? _____

_____

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Do you suffer from any of the following?

□ Hyperlipidemia	□ Coronary artery disease	□ previous heart-attacks
□ Statin intolerance	□ Osteoporosis	□ Clinical depression
□ Hemochromatitis	□ Chronic fatigue	□ Polycystic Ovarian Syndrome
□ Gallstones	□ Anorexia nervosa	□ Muscle cramps
□ Wilson's disease	□ Chronic cold	□ Kidney stones
□ Epilepsy	□ Hypothyroidism	□ Hyperthyroidism
□ Migraines	□ Heartburns or Acid reflux	□ Type I diabetes
□ Type II diabetes	□ Metformin flushing	□ Non-alcoholic fatty liver disease
□ Fibromyalgia	□ Benign prostatic hyperplasia	□ Mild cognitive impairment

If you suffered from any bone fractures in the last 3 years, which bone _____ when _____

Do you have family history of the following conditions?

□ Type II diabetes	□ Hypertension	□ Cardiovascular disease
□ Colorectal cancer	□ Dementia / Alzheimer	

Which prescription and over the counter medication do you take regularly? _____

_____

Fertility: Do you suffer from any of the following conditions? □ Chronic prostatitis □ Varicocele

If you have semen analysis results, please fill in values in the correct column according to analysis standards:

Parameter	Unit	Normal value according to Kruger strict morphology 3rd Ed	Normal value according to Kruger strict morphology 4th Ed	The World Health Organization's 5th edition of "normal semen analysis"
Volume	ml			
pH				
Concentration	million sperm / ml semen			
Total number	million sperm per ejaculate			
Motility (within 60 minutes of collection) – forward progression	%			
Motility (within 60 minutes of collection) – rapid progression	%			
Total motility	%			
Progressive motility	%			
Morphology – normal forms	%			
Vitality	%			
Leukocytes	million/ml			
Immunobead test - motile sperm with adherent particles	%			
MAR (mixed agglutination reaction) test - motile sperm with adherent particles	%			

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3 DAY DIET RECALL

Record everything that you eat and drink. Be as specific as possible as to size/amount of portion. Indicate how hungry you were and what you were doing while eating (i.e.: watching TV, driving, standing, talking etc…)

DAY 1 (*TYPICAL* ***WEEKDAY)***	***DAY 2 (****TYPICAL* ***WEEKDAY)***	***DAY 3 (****TYPICAL* ***WEEKEND)***
BREAKFAST	**BREAKFAST**	**BREAKFAST**
MID-MORNING SNACK	**MID-MORNING SNACK**	**MID-MORNING SNACK**
LUNCH	**LUNCH**	**LUNCH**
AFTERNOON SNACK	**AFTERNOON SNACK**	**AFTERNOON SNACK**
DINNER	**DINNER**	**DINNER**
AFTER DINNER SNACK	**AFTER DINNER SNACK**	**AFTER DINNER SNACK**

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QUESIONNAIRE FOR PATIENTS SUFFERING FROM CHRONIC PROSTATITIS

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas?

		Yes	No
a.	Area between rectum and testicles (perineum)	❑1	❑0
b.	Testicles	❑1	❑0
c.	Tip of the penis (not related to urination)	❑1	❑0
d.	Below your waist, in your pubic or bladder area	❑1	❑0

2. In the last week, have you experienced:

		Yes	No
a.	Pain or burning during urination?	❑1	❑0
b.	Pain or discomfort during or after sexual climax (ejaculation)?	❑1	❑0

3. How often have you had pain or discomfort in any of these areas over the last week?

- ❑0 Never
- ❑1 Rarely
- ❑2 Sometimes
- ❑3 Often
- ❑4 Usually
- ❑5 Always

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4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0	1	2	3	4	5	6	7	8	9	10
NO PAIN										PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

❑$_0$ Not at all
❑$_1$ Less than 1 time in 5
❑$_2$ Less than half the time
❑$_3$ About half the time
❑$_4$ More than half the time
❑$_5$ Almost always

6. How often have you had to urinate again less than two hours after you finished urinating, over the last week?

❑$_0$ Not at all
❑$_1$ Less than 1 time in 5
❑$_2$ Less than half the time
❑$_3$ About half the time
❑$_4$ More than half the time
❑$_5$ Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

❑$_0$ None
❑$_1$ Only a little
❑$_2$ Some
❑$_3$ A lot

8. How much did you think about your symptoms, over the last week?

- ❑0 None
- ❑1 Only a little
- ❑2 Some
- ❑3 A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- ❑0 Delighted
- ❑1 Pleased
- ❑2 Mostly satisfied
- ❑3 Mixed (about equally satisfied and dissatisfied)
- ❑4 Mostly dissatisfied
- ❑5 Unhappy
- ❑6 Terrible