UCSF Medical Center
Center for Reproductive Health

Welcome to UCSF Male Reproductive Health Practice at the Center for Reproductive Health

To prepare for your initial consultation there are **three things** you need to do:

1. Complete the new patient questionnaire and bring with you on the day of your appointment. Please arrive 15-20 minutes before your scheduled visit to complete all pre-visit paperwork and check-in.
2. Bring your insurance card and photo ID
3. Call your insurance company* to verify coverage. Fertility treatment often has limited coverage. Payment for services rendered at our clinic is required at the time of visit. We accept: cash (in exact amounts only; the front desk cannot make change), personal checks, VISA, MasterCard, American Express and Discover.

- We are located at 2356 Sutter on the 3rd floor of the Women's Health Center. Additional detail can be found at: http://mountzion.ucsfmedicalcenter.org/map.html
- If you need to cancel or reschedule your appointment, please call **(415) 353-7131** at least 48 hours in advance.

Thank you for choosing the UCSF Male Reproductive Health Practice at the Center for Reproductive Health.

*** For Patients with HMO Insurance coverage**:
In order to use your benefits, you will need to obtain AUTHORIZATION from your PCP (primary care physician). Authorizations must be in place prior to your visit. We do not accept retroactive authorizations. If you do not have this authorization at the time of visit, you will be responsible for full payment; a referral is not an authorization.

**** Due to the sensitive nature of our practice, we ask that you not bring children to our office.**

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Men's Health Questionnaire

Patient name:			
Street address:			
City:			
State:	**Zip:**	**County** (**e.g. Alameda**)**:**	
Country:			
Telephone:	**Home:**		
	Cell:		
	Work:		
E-mail:			
Date of birth:	/	/	**Age:**
Partner's name			
Partner's birthdate:	/	/	**Age:**

Primary MD Name:	Phone: ( ) -

Who referred you to the Center for Reproductive Health?		
	Physician:	Phone: ( ) -
	Insurance company	
	UCSF website	
	Former patient / friend	
	Self	

Reason(s) for Visit:			
	Fertility consultation		Ejaculation problems (e.g. rapid or delayed)
	Vasectomy reversal consultation		Low testosterone / low sex drive
	Vasectomy consultation		Urination problems (e.g. slow stream, urgency)
	Difficulty with erections		Testicle or groin pain
	Peyronie's disease		Blood in the urine
	Other (please describe):		

Marital Status:			
	Married	Years married:	
	Domestic partnership	Years together:	
	Single		

What is your racial and ethnic background? (Check all that apply)			
	African American/Black		Latino / Hispanic
	American Indian or Alaskan Native		Middle – Eastern
	Asian		Native Hawaiian or Pacific Islander
	Caucasian / White		Other:

Work Status:			
	Employed full-time		Student
	Employed part-time		Unemployed
	Self-employed		Disabled
	Retired		Other:
Place of Employment:		**Job Title**:	

Do you have any allergies to medications?		None:
Medication:	Reaction:	
Medication:	Reaction:	
Medication:	Reaction:	

Preferred Pharmacy:	
Phone:	Address:

Current Medications

	Name	Dose	Frequency	Date Started
1				/ /
2				/ /
3				/ /
4				/ /
5				/ /
6				/ /
7				/ /
8				/ /
9				/ /
10				/ /

Past Medical History: **Please select any illnesses that you may have/had.**

How would you rate your overall health?	Poor	Average	Good	Excellent

	Anemia		Immune disorder
	Asthma		Kidney disease
	Bladder stones		Kidney stones
	Bleeding disorder		Liver disease
	Blood in semen		Multiple sclerosis
	Bowel problems		Mumps
	Bronchitis		Peyronie's disease
	Cancer (Type?):		Prostatitis
	Cystic fibrosis		Sexually transmitted infection
	Depression		Sickle cell anemia/trait
	Diabetes		Spinal cord injury
	Emphysema/COPD		Stroke
	Epididymitis		Orchitis/Testicular infection
	Epilepsy/Seizures		Testicle(s) undescended at birth
	Fever (>101F) in last 3months		Testicular injury requiring hospitalization or surgery
	Genetic Condition		Thyroid disease
	Describe:		Tuberculosis (TB)
	GERD/frequent indigestion		Urethritis
	Hay fever		Urinary tract infection
	Heart problems		Vascular disease
	High blood pressure		Other:
	High cholesterol or triglycerides		

Past Surgical History: Have you had any of the following surgeries?					DATE
	Inguinal hernia repair	Left	Right	Both	/ /
	Varicocele surgery or embolization	Left	Right	Both	/ /
	Undescended testicle surgery	Left	Right	Both	/ /
	Cyst removal: testicular or scrotal	Left	Right	Both	/ /

	Past Surgical History: **Have you had any of the following surgeries?**	**DATE**
	Vasectomy	/ /
	Vasectomy reversal	/ /
	Pelvic surgery	/ /
	Back surgery	/ /
	Penile prosthesis	/ /
	Prostate surgery for urinary blockage (e.g. TURP, laser prostate surgery)	/ /
	Radiation with/without hormone treatment (Lupron) for prostate cancer	/ /
	Prostate removed for cancer (i.e. prostatectomy)	/ /
	Transplant: Which organ(s)?:	/ /
	Bladder removed for cancer (i.e. cystectomy)	/ /
	Other (please describe):	/ /

Family History: Briefly list any health issues	
Mother:	
Father:	
Grandparents:	
Maternal aunt:	
Maternal uncle:	
Paternal aunt:	
Paternal uncle:	
Brother:	
Sister:	

Social History:

Tobacco Use:		**# Years Used**		**Tobacco Type:**	
	Current every day smoker	Packs/day:		Cigarettes	
	Current some day smoker	Packs/day:		Cigars	
	Former smoker	Date quit:	/ /	Pipe	
	Non-smoker, exposed to smoke at home				
	Never smoker				

Smokeless Tobacco:		**# Years Used**	
	Current user	Amount /day:	
	Former user	Date quit:	/ /
	Never used		

Alcohol Use:		**# of alcohol drinks/week:**	
	No		Cans of beer
	Yes		Drinks containing 0.5 oz of alcohol
			Glasses of wine
			Shots of liquor

Drug Use:	No	Yes	In the past		No	Yes	In the past
Anabolic steroids				Marijuana			
Benzodiazepines				Methamphetamines			
Cocaine				Opiates			
LSD				Other:			

Sexual Activity		**Partners**	
	Not currently		Female
	No		Male
	Yes		Both female and male

Review of Systems: Do you have any problems or symptoms in the following areas?			
General		**Psychiatric**	
	Recent weight gain		Nervousness / anxiety
	Recent weight loss		Depression
	Recurrent fevers, chills, sweats		Insomnia
	Fatigue	**Skin**	
Eyes			Changing moles
	Glasses, contact lenses		Skin cancer
	Blurred or double vision	**Muscles and Joints**	
	Glaucoma		Joint stiffness or pain
Ear/Nose/Throat			Muscle pain or cramping
	Ringing in the ears		Weakness of muscles or joints
	Bleeding gums		Back pain
Genitourinary		**Allergic Immunologic**	
	Blood in the urine		Low resistance to infection
Respiratory			Recent cold or flu
	Asthma/wheezing		Environmental allergies
	Chronic cough	**Hematologic**	
	Frequent sinus infections		Easy bruising
Heart Problems			Enlarged lymph nodes
	Heart attack		Blood clots in legs or lungs
	Chest pain or angina	**Neurologic**	
	Palpitations		Numbness or tingling sensations
	Swelling of feet, ankle, or hands		Convulsions or seizures
Gastrointestinal			Worsening memory/concentration
	Decreased appetite	**Endocrine:**	
	Severe heartburn		Difficulty smelling?
	Varicose veins		Severe headaches?
	Constipation		Tunnel vision?

Reproductive History:			
Do you have **any children** with your current partner?	Yes	No	How many?
Have you had **children** with **any previous partners**?	Yes	No	How many?
When did you **stop using birth control**? (mm/dd/yyyy)	/ /		**N/A**
When did you **begin trying to get pregnant**? (mm/dd/yyyy)	/ /		**N/A**
Are you **timing intercourse** with your partner's cycles?	Yes, monthly	Yes, occasionally	No
For **how many months** have you timed intercourse?			
What **fertility treatments** have you used? (Select all that apply)			# Cycles

	Clomid or medication for you		IUI: How many cycles?
	Clomid or medication for your partner		IVF: How many cycles?
	Vasectomy reversal		IVF / ICSI: How many cycles?
	Varicocele surgery or embolization		Other:

What form of **birth control** do you use currently or have you used most recently?

	None		Diaphragm
	Condom		Rhythm (i.e. time intercourse to partner cycles)
	Birth control pills		Withdrawal (i.e. remove penis before ejaculation)
	IUD		Other:

If you have any children, please list their ages and gender:

	Age	Male	Female
Child #1			
Child #2			
Child #3			
Child #4			

Is **stress at work** a significant problem?			
	No, no significant stress		Yes, stress is a moderate problem
	Yes, stress is a small problem		Yes, stress is a big problem

Have you had exposure to any of the following:	Never	Yes, currently	Yes, in past
Chemicals or pesticides used to kill insects, rodents, or weeds?			
Radiation for treatment of cancer?			
Chemotherapy for treatment of cancer?			
Industrial solvents or dyes?			
Excessive heat in your work or hobbies?			

Did your **parents** have difficulty conceiving or maintaining/carrying a pregnancy?	Yes	No
Did your **siblings** have difficulty conceiving or maintaining/carrying a pregnancy?	Yes	No

In the past three months, **HOW OFTEN** did you use hot tubs, saunas, or Jacuzzis?					
	Never		A few times each month		Every day
	Less than once per month		Several days each week		

Partner Fertility History			**No current partner (skip partner history section)**
What is your partner's **weight** without shoes (lbs)?			
What is your partner's **height**?			
Are your partner's **menstrual cycles regular**?	Yes	No	I don't know
On average, how many days are there from the first day of one menstrual cycle to the first day of the next?			
What is the **total number** of pregnancies, children, and miscarriages your partner has had?	# Pregnancies	# Children	# Miscarriages
Has your **partner** had a **fertility evaluation?**	Yes	No	I don't know
Did she have a **normal HSG** (hysterosalpinogram)?	Yes	No	I don't know
What was her **antral follicle count** (AFC)?			I don't know

After her fertility evaluation, was your **partner diagnosed** with any of the following?			
	None, no partner infertility problems found		Fibroids
	Endometriosis		Hypothalamic or pituitary problem
	Polycystic ovary syndrome (PCOS)		Premature ovarian failure
	Irregular ovulation		Diminished ovarian reserve
	Blocked fallopian tubes		Other (please specify)

Sexual History					
How would you **rate your libido** (sex drive, interest in sex)?	Terrible	Poor	Average	Good	Excellent
How **strong** are your erections?	Extremely weak	Weak	Neither weak nor strong	Strong	Extremely Strong
When did your difficulties with erections begin? (mm/dd/yyyy)	/ /				
What do you think caused your erection problems?					
On average, how many times do you have intercourse in a typical week?	0	1-2	3-4	5-6	7+

Which medications or treatments have you tried to improve your erections? (Select all that apply)			
	None		Intraurethral suppository ("MUSE")
	Herbal therapies, Chinese medicine		Penile injections
	Oral medications (e.g. Viagra, Cialis, Levitra)		Penile prosthesis
	Vacuum erection device		Other:

Do you use any of the following **lubricants** for intercourse? (Select all that apply)					
	Preseed		Mineral oil		Olive oil or other vegetable oil
	KY jelly (or other commercial lubricant)		Egg whites		Other:

Some people have sexual relationships with men, some with women, and some with both. Have you had sexual relationships with:	Women only	Women and Men	Men only

How do you identify yourself?	Straight, heterosexual	Gay, homosexual	Bisexual	Other

Over the past six months, considering your general experiences with sex, **how distressed have you been** by these experiences?	No distress	Somewhat distressed	Moderately distressed	Very distressed	Extremely distressed
How many **hours per week** do you ride a bicycle?	0	1-2	3-4	5-6	7+
While riding your bike, how often do you experience numbness in your groin or penis?	Never	Less than ½ the time	½ the time	More than ½ the time	Every time

Sexual Health Inventory for Men (SHIM) **Over the past 4 weeks…**					
	Almost never / never	A few times (much less than ½ the time)	Sometimes (about ½ the time)	Most times (much more than ½ the time)	Almost always / always
How often were you able to get an erection during sexual activity?	1	2	3	4	5
When you had erections with sexual stimulation, **how often were your erections hard enough** for penetration?	1	2	3	4	5
During sexual intercourse, **how often were you able to maintain your erection** after you had penetrated (entered) your partner?	1	2	3	4	5
When you attempted sexual intercourse, **how often was it satisfactory** for you?	1	2	3	4	5
	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
During sexual intercourse, **how difficult** was it for you to maintain your erection to completion of intercourse?	1	2	3	4	5
	Very low	Low	Moderate	High	Very high
How did you **rate your confidence** that you could get and keep an erection?	1	2	3	4	5
SHIM Total:					

The following questions refer to your general experience with intercourse. Circle the appropriate answer.					
On average, how long does intercourse last form the time your penis enters your partner to the time you ejaculate?	< 1 minute	1-5 minutes	5-10 minutes	10+ minutes	
	Not difficult at all	Somewhat difficult	Moderately difficult	Very difficult	Extremely difficult
How difficult is it for you to delay ejaculation?	1	2	3	4	5
	Almost never or never	Less than ½ the time	½ the time	More than ½ the time	Almost always or always
Do you ejaculate before you want to?	1	2	3	4	5
Do you ejaculate with very little stimulation?	1	2	3	4	5
	Not at all frustrated	Slightly frustrated	Moderately frustrated	Very frustrated	Extremely frustrated
Do you feel frustrated because of ejaculating before you wanted to?	1	2	3	4	5
	Not at all concerned	Slightly concerned	Moderately concerned	Very concerned	Extremely concerned
How concerned are you that your time to ejaculation leaves your partner sexually unfulfilled?	1	2	3	4	5
PEDT Total:					

Urinary History

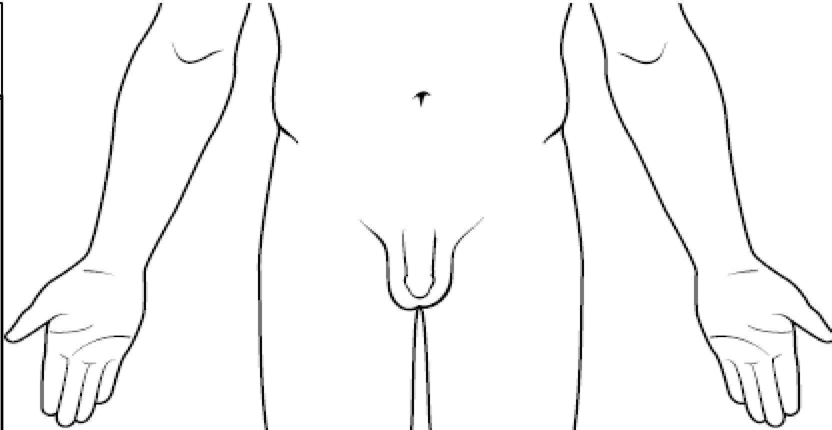
Circle 1 number on each line	Not at all	Less than 1 time in 5	Less than ½ the time	About ½ the time	More than ½ the time	Almost always
Over the past month or so, **how often have you had a sensation of not emptying your bladder** completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, **how often have you had to urinate again less than two hours** after you finished urinating?	0	1	2	3	4	5
During the past month or so, **how often have you found you stopped and started** again several times when you urinated?	0	1	2	3	4	5
During the past month or so, **how often have you found it difficult to postpone** urination?	0	1	2	3	4	5
During the past month or so, **how often have you had a weak urinary stream**?	0	1	2	3	4	5
During the past month or so, **how often have you had to push or strain** to begin urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5+ times
Over the past month, **how many times per night did you most typically get up to urinate** from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5
AUASS Total:						

	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible

How would you feel if you had to live with your **urinary** condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

Pain History		**No pain, skip this section**
When did your pain begin (mm/dd/yy)?	/ /	

Please **mark the location(s)** of your pain on the diagram.
What do you think **caused** your pain?



Using the scale below, how intense is the pain at its **worst**?	
Over the past **4 weeks**, how intense is the pain on **average**?	

How would you describe your pain? (Select all that apply)		
□ Sharp (like a knife)	□ Ache (like a tooth)	□ Pulling or pressure
□ Burning	□ Shooting	□ Comes and goes
□ Throbbing	□ Pinching	□ Constant, with me all the time

What makes the pain **worse**?	
What makes the pain get **better**?	

Have you **tried any of the following medications or treatments** for your pain?		
□ Anti-inflammatory medications (e.g. ibuprofen, naproxen)	□ Antibiotics (e.g. ciprofloxacin, doxycycline)	□ Acupuncture, Chinese medicine, naturopathic medicine
□ Narcotic pain medication (e.g. codeine, vicodin, hydrocodone)	□ Gabapentin/Neurontin	□ Spermatic cord block
□ Anti-depressant medication (e.g. paxil, celexa, nortriptyline)	□ Physical therapy	□ Spinal block
□ Other:		

Have you had a scrotal ultrasound?	□ Yes	□ No
What did this show?		