Universitair Ziekenhuis Brussel

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09/12/2016

INVUL-M-E

ENTRY FORM MAN

PERSONAL DETAILS

Date of entry ➤ ...../...../ 20.....

Name ➤ .....

Date of birth ➤ .....

Address ➤ .....

Telephone number (daytime) ➤ .....

Telephone number (evenings) ➤ .....

Mobile ➤ .....

e-mail ➤ .....

Current employment ➤ .....

IF APPLICABLE

Partner's name ➤ .....

Partner's date of birth ➤ .....

Length of your relationship ➤ .....

DETAILS OF DOCTOR

○ **No referring doctor**

Family doctor

Name ➤ .....

Address ➤ .....

.....

.....

Tel. ➤ .....

Fax ➤ .....

Practice ➤ .....

Urologist / gynaecologist

Name ➤ .....

Address ➤ .....

.....

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Tel. ➤ .....

Fax ➤ .....

Practice ➤ .....

Please specify your expectations at CRG UZ Brussel

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MEDICAL INFORMATION

Weight ➤ ..... kg Height ➤ .....cm

Blood type ➤ .....

Have you lost more than 10 kg in the last year?

○ No ○ Yes

Are you on a special diet or do you have special dietary habits?

○ No

○ Yes - Which? ➤ .....

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Do you exercise regularly?

○ No ○ Yes - In which sport(s)?

➤ .....

How many hours a week? ➤ .....

Do you use, or have you ever used, the following?

○ Alcohol - If so, how many glasses a day?

➤ .....

○ Tobacco - If so, how many cigarettes or cigars a day?

➤ .....

○ Drugs - If so, what and to what extent?

➤ .....

ENTRY FORM MAN

Do you regularly go to the sauna, take steam baths or hot jacuzzis?
○ No ○ Yes

Have you ever been exposed professionally to one of the following:
○ heat ○ chemical products
○ poisonous fumes ○ radiation
○ other (please specify) ➤ .....

Have you ever been operated upon in your abdomen, groin area or genitals?
○ No ○ Yes - Which? When? ➤ .....
.....

Have you ever had radiotherapy near your abdomen or genitals?
○ No ○ Yes

Have you taken any (prescription) medication in the past year?
○ No ○ Yes - Which? Why?
➤ .....

Have you taken any over-the-counter medication in the past year?
○ No ○ Yes - Which? Why?
➤ .....

Have you ever been treated for cancer?
○ No ○ Yes - Which type of cancer? When? ➤ .....
.....

Have you had a fever in the last 3 to 4 months (higher than 38°C)?
○ No ○ Yes

Do you suffer, or have you ever suffered, from:

- ○ allergies
- ○ anaemia
- ○ appendicitis
- ○ arthritis
- ○ blood transfusion
- ○ chlamydia infection
- ○ chronic bronchitis
- ○ chronic headaches
- ○ colitis
- ○ colour blindness
- ○ convulsions
- ○ cystic fibrosis
- ○ diabetes
- ○ dizziness
- ○ epilepsy
- ○ excessive hair growth
- ○ gall bladder problems
- ○ gonorrhoea
- ○ heart condition
- ○ hepatitis
- ○ herpes
- ○ high blood pressure
- ○ kidney infection
- ○ liver problems
- ○ loss of balance
- ○ measles
- ○ mumps with painful scrotum
- ○ neurological problems
- ○ nipple discharge
- ○ painful or sensitive chest
- ○ parasitic infection
- ○ prostate gland infection
- ○ pneumonia
- ○ poor sense of smell
- ○ rheumatism
- ○ scarlet fever
- ○ sinus infection
- ○ stomach ulcer
- ○ syphilis
- ○ testicular infection
- ○ testicular trauma
- ○ testicular tumor
- ○ thyroid problem
- ○ tuberculosis
- ○ urethritis
- ○ visual disturbances
- ○ other (please specify) ➤ .....

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MEDICAL HISTORY

When you were a child, had both testes descended into the scrotum?
○ No ○ Yes

Have you been circumcised? ○ No ○ Yes

At what age did you start to grow a beard or need to shave regularly?
➤ .....

How many times have you been married?
➤ .....

Have you ever had a child with another partner?
○ No
○ Yes - How long did it take to make your partner pregnant?
➤ .....

Did you also experience problems making a different partner pregnant?
○ No ○ Yes

Do you have any trouble getting an erection?
○ No ○ Yes

Do you have any trouble maintaining an erection?
○ No ○ Yes

Do you have trouble ejaculating?
○ No ○ Yes
- ○ premature (too soon)
- ○ retrograde ('dry ejaculation')

ENTRY FORM MAN

Do you feel that some of your semen is deposited in the vagina during intercourse?

○ No ○ Yes

Do you ever have orgasms without ejaculation when you masturbate?

○ No ○ Yes

Do you have any discharge from the penis apart from ejaculation?

○ No ○ Yes

How many times a week do you and your partner have sexual intercourse? ➤ .....

How many times do you have sexual intercourse around the time of ovulation (approximately halfway through your partner's menstrual cycle)?

➤ .....

Have you noticed a change in your libido lately?

○ No ○ Yes

FAMILY MEDICAL HISTORY

Is there a history of fertility problems in your family?

○ No ○ Yes - Who?

➤ .....

Is there any history of hormonal or congenital disorders in your family?

○ No ○ Yes - Who?

➤ .....

In your family:

○ have any children been born with abnormalities?

○ are there any known congenital disorders?

○ do members of your family have problems with cancer?

○ No ○ Yes - What? Which family member?

➤ .....

.....

INORMATION ABOUT POSSIBLE EARLIER FERTILITY TREATMENT

Since when have you and your partner been trying to get pregnant (month and year)?

➤ .....

Have you been treated for infertility before?

○ No

○ Yes - When? Who was your doctor?

➤ .....

What cause of reduced fertility was diagnosed?

➤ .....

Have you ever had varicocele (varicose veins on the testes) repair?

○ No

○ Yes - When? ➤ .....

Have you ever had a vasectomy (sterilisation)?

○ No

○ Yes - When? ➤ .....

Which of the following tests have you had? What was the result?

Test	Year	Result
○ semen analysis		
○ chlamydia test		
○ mycoplasma test		
○ antibody test		
○ chromosome test (karyotype)		
○ testicular biopsy		
○ testicular ultrasound		
○ hormonal test (FSH, LH, prolactin, testosterone)		
○ thyroid tests		
○ ultrasound of prostate		
○ other (please specify)		
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.....	.....	.....
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ENTRY FORM MAN

Has your partner had children with another man?

- ○ No
- ○ Yes - Date(s) of birth?
  - ➤ .....
  - ➤ .....
  - ➤ .....

Is your partner seeing a doctor for infertility evaluation?

- ○ No
- ○ Yes - Which doctor?
  - ➤ .....

Does that doctor feel that your partner has an infertility problem?

- ○ No
- ○ Yes - What is the diagnosis and what treatment was suggested?
  - ➤ .....
  - .....
  - .....

What fertility drugs have you taken?

- ○ none
- ○ clomiphene citrate (Pergotime®, Clomid®)
- ○ hMG (Menopur®)
- ○ tamoxifen (Nolvadex®, Tamizan®)
- ○ bromocriptine (Parlodel®)
- ○ testosterone (Proviron®, Sustanon®, Testocaps®, Undestor®, Testim®, Androgel®)
- ○ hCG (Pregnyl®, Choragon®)
- ○ LHRH, GnRH (HRF®)
- ○ FSH (Puregon®, Gonal-F®)
- ○ other (please specify) ➤ .....
  - .....
  - .....

Have you and your partner ever tried artificial insemination?

- ○ No
- ○ Yes - With what sperm?
  - ○ My sperm ○ Donor sperm
  - How many cycles? ➤ .....
  - What was the result (pregnant or not)? ➤ .....

Have you and your partner ever tried IVF or ICSI?

- ○ No
- ○ Yes
  - When ➤ .....
  - .....
  - .....
  - Where ➤ .....
  - .....
  - .....
  - .....
  - Result ➤ .....
  - .....
  - .....
  - .....

Which other possible treatment have you and your partner undergone with regards to your fertility problem?

➤ .....
.....
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