



ENTRY FORM MAN

INVUL-M-E

PERSONAL DETAILS

Date of entry ▶ / /

Name ▶

Partner's name ▶

Length of your relationship ▶

Address ▶

Date of birth ▶ Partner's date of birth ▶

Telephone number (Day) ▶ Telephone number (evening) ▶

Mobile ▶ e-mail ▶

Current employment ▶

DETAILS OF DOCTOR

No referring doctor

Family doctor

Name ▶

Address ▶

Tel. ▶

Fax ▶

Practice ▶

Urologist/gynaecologist

Name ▶

Address ▶

Tel. ▶

Fax ▶

Practice ▶

MEDICAL HISTORY

Weight ▶ kg Height ▶ cm

Blood type ▶

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

No Yes

Have you ever been exposed during your military service to one of the following:

heath chemical products

poisonous odours radiation

other (please specify) ▶

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

No Yes (if yes, please specify) ▶

Do you exercise regularly?

No Yes (if yes, please specify) ▶

How many hours a week? ▶

Do you regularly go to the sauna, take steam baths or hot jacuzzis?

No Yes

Have you ever been operated upon in your abdomen, groin area or genitals?

No Yes (please specify what and when) ▶



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

- | | |
|--|--|
| <input type="radio"/> Acute rheumatism | <input type="radio"/> Colour blindness |
| <input type="radio"/> Allergies | <input type="radio"/> Liver problems |
| <input type="radio"/> Anaemia | <input type="radio"/> Pneumonia |
| <input type="radio"/> Appendicitis | <input type="radio"/> Stomach ulcers |
| <input type="radio"/> Arthritis | <input type="radio"/> Measles |
| <input type="radio"/> Blood transfusion | <input type="radio"/> Neurological problems |
| <input type="radio"/> Mumps with painful scrotum | <input type="radio"/> Kidney infection |
| <input type="radio"/> Chlamydia infection | <input type="radio"/> Prostate gland infection |
| <input type="radio"/> Chronic bronchitis | <input type="radio"/> Testicular infection |
| <input type="radio"/> Chronic headache | <input type="radio"/> Excessive hair growth |
| <input type="radio"/> Chronic sinusitis | <input type="radio"/> Parasitic infection |
| <input type="radio"/> Colitis | <input type="radio"/> Scarlet fever |
| <input type="radio"/> Diabetes | <input type="radio"/> Thyroid problem |
| <input type="radio"/> Dizziness | <input type="radio"/> Convulsions |
| <input type="radio"/> Epilepsy | <input type="radio"/> Syphilis |
| <input type="radio"/> Loss of balance | <input type="radio"/> Cystic fibrosis |
| <input type="radio"/> Gall bladder problems | <input type="radio"/> Breast discharge |
| <input type="radio"/> Sensitive chest | <input type="radio"/> Testicular trauma |
| <input type="radio"/> Gonorrhoea | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Heart disease | <input type="radio"/> Testicular tumor |
| <input type="radio"/> Hepatitis | <input type="radio"/> Urethritis |
| <input type="radio"/> Herpes | <input type="radio"/> Visual disturbances |
| <input type="radio"/> High blood pressure | |

Have you ever had radiotherapy near your abdomen or genitals?

- No Yes

Have you ever been treated for cancer?

- No
 Yes (please specify what and when)

.....

Have you taken any (prescribed) medication in the past year?

- No
 Yes, (please specify which medication and why you were taking it)

.....

Have you taken any over-the-counter medication in the past year?

- No
 Yes, (please specify which medication and why you were taking it)

.....

Have you had a fever in the last 3 to 4 months (higher than 38°C)?

- No Yes

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

- Alcohol (if yes, how many glasses a day?)

.....

- Tobacco (if yes, how many cigarettes or cigars a day)

.....

- Drugs (if yes, what and to what extent?)

.....

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 (if 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')



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 HISTORY

Is there a history of fertility problems in your family?

- No
 Yes (if yes, who)

.....

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

- No
 Yes (if yes, who?)

.....

- Have any children in the family been born with abnormalities?
- Are there any known congenital disorders in the family?
- Do the men or women in your family have problems with cancer?

- No
 Yes (if yes, what and who?)

.....

FERTILITY TREATMENT HISTORY

How long are you and your partner trying to get pregnant?

(month/year) ▶

Have you been treated for infertility before?

- No
 Yes (if so, when and who was your doctor?)

.....

.....

What cause of reduced fertility was diagnosed?

.....

.....

Which of the following tests have you had and what was the result (if known)?

Test	Year	Result
<input type="radio"/> Semen analysis	
<input type="radio"/> Chlamydia test	
<input type="radio"/> Mycoplasma test	
<input type="radio"/> Antibody test	
<input type="radio"/> Chromosome test (karyotype)	
<input type="radio"/> Testicular biopsy	
<input type="radio"/> Testicular ultrasound	
<input type="radio"/> Hormonal tests (FSH, LH, prolactin, testosterone)	
<input type="radio"/> Thyroid tests	
<input type="radio"/> Ultrasound of prostate	
<input type="radio"/> Other (please specify)	
.....	
.....	
.....	

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

- No
 Yes (if so, when?) ▶

Have you ever had a vasectomy (sterilisation)?

- No
 Yes (if so, when?) ▶



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Has your partner had children with another man?

- No
- Yes (if yes, when?)
 ▶

Is your partner seeing a doctor for infertility evaluation?

- No
- Yes (if yes, specify doctor)
 ▶

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

- No
- Yes (if yes, what is the diagnosis and has a treatment been proposed?)
 ▶

What fertility drugs have you taken?

- None
- Clomiphene citrate (Pergotime®, Clomid®)
- hMG (Humegon®, Menopur®)
- Tamoxifen (Nolvadex®, Tamizan®)
- Bromocriptine (Parlodel®)
- Testosterone (Proviron®, Sustanon®, Testocaps®, Undestor®, Testim®, Androgel®)
- hCG (Pregnyl®, Choragon®)
- GnRH or LHRH (HRF®)
- FSH (Puregon®, Gonal-F®)
- Other (specify) ▶

Have you and your partner ever tried artificial insemination?

- No
- Yes (if yes, using partner or donor sperm?)
 - Partner 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?

- ▶

