INVUL-
M E

ENTRY FORM MAN

PERSONAL DETAILS

Date of entry ▶ ....
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 ▶ ....
....
....
Tel. ▶ ....
Fax ▶ ....
Practice ▶ ....

Please specify your expectations at IVF Brussel?

....
....
....

MEDICAL INFORMATION

Weight ▶ .... Height ▶ ....
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? ▶ ....
....
....

Do you exercise regularly?
◯ No ◯ Yes - Which?
▶ ....

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?
▶ ....

Brussels IVF
Laarbeeklaan 101 T +32 2 477 66 99 info@brusselsivf.be
1090 Brussel brusselsivf.be

INVUL-
M E

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) ▸ ....

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 or children with another partner?
◯ No
◯ Yes - How long did it take to achieve pregnancy?
▸ ....

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)		
....	....	....
....	....	....
....	....	....

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?

▸ ....

....

....