Duke Fertility Center

Date: _____

Duke Fertility Center
Reproductive Urology Intake Form

Patient Name: _____ Partner Name: _____

SSN or History #: _____

Date of Birth: _____

Height: _____ Weight: _____ Phone (day): _____

Race: _____ Hispanic or Latino: ☐ Phone (night): _____

Education Level: _____ Email: _____

Occupation: _____

MEDICAL HISTORY

Current Medications: _____

_____

Please indicate if you have had medical problems with any of the following areas:

Body System	Yes	No	Year	Currently?	Description/Medication
Skin	☐	☐			
Head, eyes, ears, nose, throat	☐	☐			
Lungs (including tuberculosis)	☐	☐			
Heart or blood vessels (including high blood pressure)	☐	☐			
Stomach/intestines	☐	☐			
Liver	☐	☐			
Hormones/metabolism (including diabetes, thyroid disorder, abnormal puberty)	☐	☐			
Nervous system/brain function	☐	☐			
Psychiatric condition	☐	☐			
Hematologic/Lymphatic (including anemia, transfusion)	☐	☐			
Muscles/bones	☐	☐			
Allergies (inculde medication allergies and reaction when taken)	☐	☐			
Infection with fever in past year	☐	☐			
Sexually transmitted diseases; Chlamydia, Hepatitis B or C, Gonorrhea, Syphilis, other	☐	☐			
Childhood diseases: Chicken pox, Measles, Mumps, other	☐	☐			
Cancer (include type of cancer, chemo, radiation and where radiation directed)	☐	☐			
Urological problems	☐	☐			
Other major illness	☐	☐			

SURGICAL HISTORY

	Yes	No	Year	Description
When younger, did your testes have to be surgically brought to your scrotum?	☐	☐		
Have you had a hernia repair?	☐	☐		☐ Right side ☐ Left side ☐ Both sides
Have you had surgery to improve fertility?	☐	☐		
When younger, did your testes ever twist (torsion), requiring surgery to untwist?	☐	☐		☐ Right side ☐ Left side ☐ Both sides
Have you ever had a varicocele repair?	☐	☐		☐ One side ☐ Both sides
Have you experienced major trauma to your testes?	☐	☐		
Bladder surgery	☐	☐		
Prostate surgery	☐	☐		
Other surgery	☐	☐		

SEXUAL HISTORY

Have you ever had...	Yes	No
Difficulty achieving an erection?	☐	☐
Difficulty maintaining an erection?	☐	☐
Difficulty with premature ejaculation?	☐	☐
Pain with ejaculation?	☐	☐
Blood in your ejaculation?	☐	☐

How often do you have intercourse?	# times: _____ ☐ Per week ☐ Per month
How often do you have sexual activity?	# times: _____ ☐ Per week ☐ Per month

FERTILITY HISTORY

Please list all pregnancies with current or prior partner(s):

Pregnancy	Complication (if yes, describe)	Malformation (if yes, describe type and if with current or prior partner)
1		
2		
3		
4		
5		

How long have you and your partner been trying to conceive? _____

Have you ever had any types of fertility problems? ☐ Yes ☐ No

If yes, explain briefly what type of problem and what treatment has been done: _____

_____

Have you ever had a semen analysis? ☐ Yes ☐ No

If yes, results? _____

Date	Volume	Count	Motility	Morphology	Other

Have you ever been tested for Antisperm Antibodies? ☐ Yes ☐ No

If yes, results? _____

Have you ever taken any Fertility Medications? If yes, note for how long: _____

Clomid	☐ Yes ☐ No	Aromatase injections	☐ Yes ☐ No
Gonal F	☐ Yes ☐ No	Anastrozole	☐ Yes ☐ No
Bravelle	☐ Yes ☐ No	Testolactone	☐ Yes ☐ No
Follistim	☐ Yes ☐ No	Other	☐ Yes ☐ No
HCG or LH injections	☐ Yes ☐ No		

Have you been diagnosed with any of the following genetic conditions?

Cystic Fibrosis ☐ Yes ☐ No

Klinefelters ☐ Yes ☐ No

Y chromosome microdeletions ☐ Yes ☐ No

Other: _____

EXPOSURE HISTORY/FAMILY HISTORY

Type	Yes	No	How often and last occurrence
Hot baths	☐	☐	
Sauna	☐	☐	
Whirlpool	☐	☐	
Work chemicals or pesticides	☐	☐	
Large amounts of radiation	☐	☐	
Lengthy exposure to radiation	☐	☐	
Current smoker	☐	☐	# per day: _____ # years smoking: _____
Past smoker	☐	☐	Year quit: _____ # years: _____ # per day: _____
Coffee/caffeinated drinks	☐	☐	# per day: _____
Marijuana (current/past)	☐	☐	How often? _____
Recreational drugs	☐	☐	Type: _____ Frequency: _____
Anabolic steroids/bodybuilding drugs	☐	☐	Type: _____ Frequency: _____
Alcoholic beverages	☐	☐	# per week: _____
Current calorie restricting diet	☐	☐	If yes, daily caloric intake: _____
Regular exercise	☐	☐	If yes, type and frequency: _____
Recent weight loss	☐	☐	If yes, lbs lost: _____ Frequency: _____
Current vitamins, supplements, herbals	☐	☐	If yes, type: _____ Frequency: _____
Any blood relatives with fertility issues?	☐	☐	If yes, who: _____
Did your mother take DES when pregnant with you?	☐	☐	DES is a tablet that was given to women with a history of miscarriage or bleeding during pregnancy.

Do you have a family history of any of the following? Check all that apply.

☐ Birth defects
☐ Brain/spinal defects
☐ Cancer
☐ Cystic Fibrosis
☐ Diabetes
☐ Down Syndrome
☐ Fragile X Syndrome
☐ Heart disease
☐ Hemophilia
☐ High Blood Pressure
☐ Muscular Dystrophy
☐ Sickle Cell Disease
☐ Tay Sachs Disease
☐ Thalassemia
☐ Thyroid Disease

If yes, who: _____

Are you from any of these ethnic backgrounds? Check all that apply.

☐ Italian	☐ Jewish	☐ Caucasian	☐ African American
☐ Greek	☐ French Canadian/Cajun	☐ African	☐ Middle Eastern
☐ Hispanic	☐ Spanish	☐ Southern Chinese	☐ Asian Indian
☐ Taiwanese	☐ Filipino	☐ Southeast Asian	

Other: _____

If yes, have you had any specific genetic testing to see if you are a carrier of a genetic disease? ☐ Yes ☐ No

Specify: _____

Are there any other issues you would like to share with us? _____

_____

_____

_____

_____

Thank you very much for completing this questionnaire!

Patients will be seen by urologist Karen Baker, MD.