THE UROLOGY GROUP

www.urologygroupvirginia.com

1860 Town Center Drive • Suite 150 • Reston, VA 20190 • 703-480-0220
19415 Deerfield Avenue • Suite 112 • Leesburg, VA 20176 • 703-724-1195 224-D
Cornwall Street, NW • Suite 400 • Leesburg, VA 20176 • 703-443-6733

FERTILITY EVALUATION

Patient Name:_____Date of Birth:_____

How long have you been trying to achieve pregnancy?_____

Medical History

Childhood illnesses _____

History of undescended testicle?_____

Trauma or heat to the scrotum/testicles? _____

History of sexually transmitted infections? _____

Alcohol_____Tobacco_____Drugs (e.g. marijuana, testosterone) _____

Reproductive History

Have you had any prior fertility problems? _____

Have you ever achieved pregnancy before?_____Had children?_____

Any problems with erection?_____Ejaculation?_____

How often do you have sex?_____Do you time sex around the time of ovulation?_____

Family History

Family history of fertility problems?_____

Partner's History

Your partner's age_____Has your partner ever been pregnant?_____Had children? _____

Does your partner have history fertility problems? _____

Has your partner had a fertility evaluation?_____Results? _____

Written by: Jennifer L. Young MD, The Urology Group.
Reference: The Optimal Evaluation of the Infertile Male: American Urological Association Best Practice Statement. Revised, 2010.

www.auanet.org/content/media/optimalevaluation2010.pdf