

THE UROLOGY GROUP

www.urologygroupvirginia.com

1860 Town Center Drive • Suite 150/160 • 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
24430 Stone Springs Blvd • Ste 100 • Dulles • VA 20166

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. Copyright 2012.

Reference: The Optimal Evaluation of the Infertile Male: American Urological Association Best Practice Statement. Revised, 2010.

©2010 American Urological Association, Education and Research Inc., Linthicum, MD.

www.auanet.org/content/media/optimizevaluation2010.pdf