LYNNE CHAPMAN
REPRODUCTIVE HEALTH

HEALTH QUESTIONNAIRE – MALE

Please complete this questionnaire and provide:

- ***A copy of your passport or ID card. Original documents will be required at your initial consultation.***
- ***Any further documentation / test results or reports.***

Title (Dr/Mr Etc.):	
Surname:	
Forenames(s):	
Preferred Name:	
Previous Surname(s):	
Date of Birth:	
Age:	
Occupation:	
Passport / ID Number:	
Country of Issue:	
Relationship Status:	☐ Married / Civil Partner (with person intending to have treatment with) ☐ Married / Civil Partner (with another person) ☐ Cohabiting ☐ Single ☐ Divorced ☐ Widow ☐ Legally Separated
Address:	
City:	
Postcode:	
Country:	
Place of Birth:	

Country of Birth:				
	Telephone (Home):	☐		*Please include at least one contact number, preferably your mobile number.*
	Telephone (Work):	☐		
	Telephone (Mobile):	☐		
	Please provide your email address:	☐		

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Do you consent to receiving reminders by text message?:	Yes ☐ No ☐	
To protect your privacy, and to comply with General Data Protection Regulations, all clinical correspondence will be encrypted via Egress. You will receive an encrypted email which will prompt you to create an Egress user account. You will only need to do this once. Any subsequent emails sent will require you to merely sign into the account to access your email. ***Please note we are not permitted to send clinical information unencrypted unless we receive your request in writing that you do not wish to receive encrypted emails.***		
PLEASE CHOOSE EITHER OPTION 1 OR 2 FOR EMAIL COMMS 1. I confirm that I give my consent to receive unencrypted emails from LCRH to my personal email account as detailed above in this form.	☐ Yes ☐ No	Please tick Y if we may contact you at your personal email address.
2. I confirm that I prefer the use of **ONLY** an Egress encrypted email account for all email communication with LCRH and no emails should be sent to my personal email account under any circumstances.	☐ Yes ☐ N/A	If you tick Y here, we will not send any emails to you at your personal email address.
IMPORTANT Do you consent to share ALL your blood test and all other results with your partner here named?	Yes ☐ No ☐	Confirm Name of Partner & your initial: ……. ……..

	If no, pls specify which tests **may not** be shared	
Do you have a disability:	Yes ☐ No ☐	
If yes, please give details		
GP DETAILS		
GP Name:		
GP Surgery Name:		
GP Address:		
GP Address City:		
GP Address Postcode:		
GP telephone Number:		

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EMERGENCY CONTACT	
In the event of a medical emergency, please specify emergency contact person:	☐ Person with whom you are having treatment ☐ Other
Emergency contact name:	
Emergency contact telephone:	

Reason for contacting LCRH:	☐ Primary infertility (no pregnancies) ☐ Secondary infertility (previous pregnancies in current relationship) ☐ Secondary infertility (previous pregnancies in a different relationship) ☐ Recurrent Miscarriage ☐ Single person ☐ Same sex couple ☐ Fertility preservation due to medical reasons ☐ Fertility preservation for social reasons ☐ PGD to reduce risk of passing on genetic disorder ☐ To be an sperm donor	
Have you ever fathered a pregnancy? *Including miscarriages, ectopic, TOPs*	☐ Yes ☐ No	*If no, please proceed to next section*
Year of pregnancy		
Was it with the partner you are seeking treatment with?	☐ Yes ☐ No	
Conception method:	☐ Natural ☐ Assisted Conception	
Pregnancy outcome:		
Number of weeks gestation:		
Comments:		
Year of pregnancy		
Was it with the partner you are seeking treatment with?	☐ Yes ☐ No	
Conception method:	☐ Natural ☐ Assisted Conception	

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Pregnancy outcome:	
Number of weeks gestation:	
Comments:	
Year of pregnancy	
Was it with the partner you are seeking treatment with?	☐ Yes ☐ No
Conception method:	☐ Natural ☐ Assisted Conception
Pregnancy outcome:	
Number of weeks gestation:	
Comments:	

Does your job expose you to any of the following?	Heat ☐ Yes ☐ No Chemicals ☐ Yes ☐ No Pesticides ☐ Yes ☐ No Radiation ☐ Yes ☐ No
Have you ever had twisting of a testicle?	☐ Yes ☐ No
Have you ever had a diagnosis of a varicocele?	☐ Yes ☐ No
Have you had mumps?	☐ Yes ☐ No
Have you ever had a sexually transmitted disease? Please give details	☐ Yes ☐ No

Do you have difficulties / problems with intercourse?	Erection ☐ Yes ☐ No Ejaculation ☐ Yes ☐ No Penetration ☐ Yes ☐ No Pain ☐ Yes ☐ No	
Have you ever had a surgical procedure?	☐ Yes ☐ No	*If yes, please give details in boxes below.*

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Procedure type:	
Procedure date:	
Anaesthetic type:	
Testicular?	
Abdominal?	
Comments:	
Procedure type:	
Procedure date:	
Anaesthetic type:	
Testicular?	
Abdominal?	
Comments:	
Did you have any complications during these procedures?	☐ Yes ☐ No
Do you have any medical conditions? *e.g. Asthma, epilepsy, diabetes, anaemia, colitis etc.*	☐ Yes ☐ No *If yes, please give details below*

Do you have a family history of any medical conditions? *e.g. cancer, heart disease, genetic disease,*	☐ Yes ☐ No *If yes, please give details below*
Are you taking any medications currently? *If yes, please give details*	☐ Yes ☐ No
Do you have any allergies? *If yes, please give details*	☐ Yes ☐ No
Do you smoke? *If yes, indicate how many per day*	☐ Yes ☐ No ☐ Cigarettes ☐ Cigars ☐ Other
Do you drink alcohol? *If yes, how many units per week?*	☐ Yes ☐ No Units:
Do you drink caffeine? *If yes, how much per day?*	☐ Yes ☐ No Daily Intake:
Do you use recreational drugs?	☐ Yes ☐ No

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If yes, please give details and frequency of use			
Do you use performance-enhancing drugs such as steroids/Viagra/protein supplements? *If yes, please give details*	☐ Yes ☐ No		
Have you travelled to a Zika or Ebola affected area in the last six months? *If yes, please give details of location and dates of travel*	☐ Yes ☐ No		
Height (metres)		BMI	
Weight (kilograms)		You can find many Body Mass Indicator (BMI) calculators online (eg:	

		https://www.nhs.uk/live-well/healthy weight/bmi-calculator/)

Have you ever had any fertility investigations? *e.g. Semen analysis, karyotyping, Cystic fibrosis screening, Testosterone, LH, TSH*	☐ Yes ☐ No *If yes, please give details, dates and results below*	
Have you ever had assisted conception treatment before? *e.g. Ovulation Induction, IUI, IVF, ICSI*	☐ Yes ☐ No	*If no, please proceed to section H*
Was the treatment with the partner you are seeking treatment with?	☐ Yes ☐ No ☐ N/A	
Please give all details of fertility treatments on the next page. Please attach any further details with this questionnaire or bring to your initial consultation so we can tailor your treatment at LCRH		

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	1st Treatment	2nd Treatment	3rd Treatment	4th Treatment	5th Treatment	6th Treatment
Year of Treatment						
Treatment Type						
Centre						
Sperm Source						
PGD / PGD?						

Number of eggs collected:						
Number fertilised?						
Number of embryos transferred & day of transfer:						
Number of embryos frozen & day of freeze:						
Pregnant?						
Outcome:						
Any cycle complications						

Do you have any frozen eggs, sperm or embryos in storage elsewhere?	☐ No ☐ Partner Eggs ☐ Sperm ☐ Donor sperm ☐ Embryos	Location of samples:

Do you have any further information you wish to make LCRH aware of? *If yes, please details below*	☐ Yes ☐ No		
How did you hear about LCRH?	☐ Yes Fertility Solutions	☐ Yes Google	☐ Yes Other (please name)

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Do you eat more than 5 portions of fruit and veg per day?	Ensuring at least 5 portions will nourish your body with essential vitamins, minerals and fibre
Do you skip meals?	Eating regular meals can support your body with the required nutrient for optimal health.
Do you regularly crave sugary foods?	Cravings can be controlled with a portion of wholegrain carbohydrate at every meal in addition to your fibrous veggies
Do you take any nutritional supplements?	It is important to give attention to this area when trying to conceive as requirements in the body change. A vitamin D and folic acid supplement are a must!
Do you drink more than 2 cups of coffee (4 cups of tea) per day?	Caffeine must be reduced during this time
Do you regularly eat confectionary foods, eat out or order takeaways?	These foods are high in added sugar, saturated fat and salt... all areas you should try to limit.
Do you suffer with poor digestion?	Ensure you are eating 30g of fibre per day in addition to drinking 8 glasses of fluid.
Do you drink alcohol at the moment?	It is always best to limit alcohol to less than 14 units per week and when you conceive, to cut it out completely
If you would like to understand more about your individual dietary requirements, please ask us to recommend a Nutritionist.	

Thank you for providing this information