

Date: _____

Male Fertility Questionnaire

Identifying Information

Name: _____ Date of Birth: _____ Age: _____
Address: _____ Phone (Home): _____
_____ Phone (Mobile): _____
Race: _____ Ethnic Background: _____
Employer: _____
Occupation: _____ Hours Worked: _____
Extensive Travel: Y / N

Are you interested in using your sperm? Y / N
Are you interested in using your partner's sperm? Y / N
Have you identified an egg donor? Y / N
Have you identified a gestational carrier? Y / N
Are you uncertain? Y / N

Medical History

Weight: _____ Height: _____ Blood Group and RH: _____
Do you follow a particular diet or have any special dietary habit: Y/N
If yes, explain: _____
Do you exercise on a regular basis? Y/N
If yes, detail frequency and form of exercise: _____
Nicotine Usage: Y / N If no, have you smoked previously? _____
If yes, for how long/Cigarettes per day: _____
Caffeine Usage: Y / N If yes, Cups per Day: _____
Alcohol Usage: Y / N Average Weekly Consumption: _____
Recreational Drug Usage: Y / N If yes, specify: _____

Activities performed more than 3 times per week:

- Hot baths, saunas Bicycling Long Distance Driving

Allergies (Please List): _____

Current Prescription Medication: _____

Current Over-The-Counter Medication: _____

Do you have or have you ever had: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Epididymitis |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Prolonged Fever | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Urethritis |
| <input type="checkbox"/> Congenital disease | <input type="checkbox"/> Inguinal Hernia | <input type="checkbox"/> Undescended Testicle |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mumps w/Testicular Involvement | <input type="checkbox"/> Injury to Testicle |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Varicocele |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Orchitis | <input type="checkbox"/> Hydrocele |
| <input type="checkbox"/> Psychiatric Disorder | | |

If yes to any, or to add something that was not listed, please explain: _____

Surgical History

Please list any previous surgical procedures you have had and when they were performed: _____

Sexual and Marital History

Sexual History:

Frequency per month: _____ Difficulties: _____
Pain or Discomfort? _____ Erection? _____
Do you use lubrication during intercourse? _____ If yes, what: _____
Ejaculation (Normal or Premature): _____ Masturbation: _____
Premarital sex experience: _____

Marital History:

Number of years: _____ Date of marriage: _____
Number of children: _____ Number of adopted children: _____
Infertility? _____ If yes, for how long: _____
Marital Problems: _____

Family History

Have there been any of the following diseases in your family?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Abnormal genitalia | <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Recurrent miscarriage | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Cleft lip or palate |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Children born with malformations | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Limb deformities |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other congenital abnormalities | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Schizophrenia or depressive psychosis | <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Deafness |
| <input type="checkbox"/> Cancer | | <input type="checkbox"/> Spina bifida | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Cystic Fibrosis | | | |
| <input type="checkbox"/> Sickle Cell Disease | | | |
| <input type="checkbox"/> Early deaths | | | |

If the answer to any of the above is yes, please elaborate: _____

Fertility History

Have you ever had a vasectomy? Y / N

If yes, when: _____

Have you ever had a vasectomy reversal? Y / N

If yes, when: _____

Have you ever had any previous fertility testing? Y / N

If yes, who was your physician? _____

Was a specific diagnosis identified? _____

Have you fathered a pregnancy? Y / N

If yes, outcome of pregnancy (s):

- | | |
|--------------------------------------|---------------|
| <input type="checkbox"/> Abortion | Number: _____ |
| <input type="checkbox"/> Miscarriage | Number: _____ |
| <input type="checkbox"/> Livebirth | Number: _____ |

Which of the following tests have you had performed? Check all that apply:

- | | | |
|---|-------------|----------------|
| <input type="checkbox"/> Urological Exam | When: _____ | Results: _____ |
| <input type="checkbox"/> Semen Analysis | When: _____ | Results: _____ |
| <input type="checkbox"/> Scrotal Ultrasound | When: _____ | Results: _____ |
| <input type="checkbox"/> Hormone Testing | When: _____ | Results: _____ |

Anything else you wish to share that we have not yet asked: _____



Questions to Ask your Insurance Regarding Fertility/Infertility Coverage

Insurance benefits vary widely dependent upon insurance company, insurance plan, where your company is headquartered, or if your plan is self-insured.

Please complete this insurance verification form prior to your initial consultation with the doctor. Use this form as a questionnaire when calling the member services phone number on your insurance card.

It is your responsibility to call your insurance company to review your fertility benefit. Once you have this information, it is your responsibility to inform office staff of benefit information and/or change of insurance.

Patient Name: _____ Patient DOB _____

Provider: _____

ID Number: _____ Group: _____

Questions to ask:

General:

- o Am I in-network with Dr. Wood Molo and the Center for Reproductive Care?

- o What is my deductible/coverage once deductible met:

- o What is my specialist office visit copay?

Fertility Testing: (Diagnosis Code: Z31.41)

- o Are there any restrictions or exclusions to be eligible for fertility benefit?

- o Do I have fertility testing coverage? (CPT: 76856, 76857, 74740, 76830, 76831, 58340)

- o Do I need to register with the insurance as a fertility patient?

Fertility Treatment: (Diagnosis Code(s): N97.9, Z31.83)

- o Do I qualify for infertility benefits?

- Do I have fertility treatment coverage?

- Do I have Intrauterine Insemination (IUI) Coverage? (CPT Code: 58322)

- Do I have In Vitro Fertilization (IVF) Coverage? (CPT: 58970, 58974)

- Do I have any lifetime or yearly limits for fertility treatments?

- Does my insurance require a prior authorization before treatment begins?
 - If yes, what is the contact information for the prior-authorization department?

- Do I have infertility medication coverage?
 - If yes, what is my specialty pharmacy?

- Do my medications count towards my lifetime or yearly fertility allowance?

Fertility Preservation (Diagnosis Code(s): Z31.62, Z31.84)

- Does my plan cover fertility preservation counseling?

- Does my plan have any exclusions for Egg Retrieval CPT 58970?

Donor Egg: (Diagnosis Code: Z51.810)

- If I am using an egg donor, will her medical services and/or medications be covered?

Date: _____

Representative: _____

Reference #: _____