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

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)

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Prolonged Fever
- ☐ Congenital disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Psychiatric Disorder
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Inguinal Hernia
- ☐ Mumps w/Testicular Involvement
- ☐ Epilepsy
- ☐ Orchitis
- ☐ Epididymitis
- ☐ Prostatitis
- ☐ Urethritis
- ☐ Undescended Testicle
- ☐ Injury to Testicle
- ☐ Varicocele
- ☐ Hydrocele

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?

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

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):

- ☐ Abortion Number: _______
- ☐ Miscarriage Number: _______
- ☐ Livebirth Number: _______

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

- ☐ Urological Exam When: _________________ Results: _____________________
- ☐ Semen Analysis When: _________________ Results: _____________________
- ☐ Scrotal Ultrasound When: _________________ Results: _____________________
- ☐ 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:

- Am I in-network with Dr. Wood Molo and the Center for Reproductive Care?
  ____
- What is my deductible/coverage once deductible met:
  ____
- What is my specialist office visit copay?
  ____

Fertility Testing: (Diagnosis Code: Z31.41)

- Are there any restrictions or exclusions to be eligible for fertility benefit?
  ____
- Do I have fertility testing coverage? (CPT: 76856, 76857, 74740, 76830, 76831, 58340)
  ____
- Do I need to register with the insurance as a fertility patient?
  ____

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

- 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 #: ____________________