Center for Reproductive Care
MARY WOOD MOLO, MD

Date: _____

Trans Female Fertility Questionnaire

Identifying Information

Legal Name: _____ Date of Birth: _____
Preferred Name:_____
Legal Gender:_____
Age:____
Address: _____ Phone (Home): _____
_____ Phone (Mobile): _____
Race: _____ Ethnic Background: _____
Employer: _____
Occupation: _____ Hours Worked: _____
Extensive Travel: --
Referring Physician _____

Are you interested in using your sperm? --
Are you interested in using your partner's sperm or eggs? --
Have you identified a gestational carrier? --
Are you interested in:
Egg Donor? --
Sperm Donor? --
Gestational Carrier? --

Gender Identity_____
Sex assigned at birth_____
Identifying pronoun preferred_____

Chief Medical Problem

Describe the reason for your visit: _____
_____

Medical History

Weight: _____ Height: _____ Blood Group and RH: _____
Do you follow a particular diet or have any special dietary habit --
If yes, explain: _____
Do you exercise on a regular basis? --
If yes, detail frequency and form of exercise: _____

Nicotine Usage: --
If no, have you smoked previously? _____
If yes, for how long/Cigarettes per day: _____
Caffeine Usage: --
If yes, Cups per Day: _____
Alcohol Usage: --
Average Weekly Consumption: _____

Recreational Drug Usage: -- If yes, specify: _____

Activities performed more than 3 times per week:

☐ Hot baths, saunas ☐ Bicycling ☐ Long Distance Driving

Allergies (Please List): _____

Current Prescription Medication: _____

Have you used hormones for gender identity purposes? --

If so, which ones:

_____

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

- ☐ Top Surgery
- ☐ Bottom Surgery
- ☐ Removal of Testes
- ☐ Gender Confirming Surgery

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

_____

_____

Sexual and Marital History

Sexual History:

Frequency per month: _____ Difficulties: _____

Marital History:

Number of years: _____ Date of marriage: _____

Number of children: _____ Number of adopted children: _____

Infertility? _____ If yes, for how long: _____

Please list any questions, concerns, or comments you have.

_____

_____

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? --

If yes, when: _____

Have you ever had a vasectomy reversal? --

If yes, when: _____

Have you ever had any previous fertility testing? --

If yes, who was your physician? _____

Was a specific diagnosis identified? _____

Have you fathered a pregnancy? --

If yes, outcome of pregnancy (s):

- ☐ Abortion Number: _____
- ☐ Miscarriage Number: _____
- ☐ Livebirth Number: _____

Have you cryopreserved (frozen) your sperm? --

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

- ☐ Urological Exam When: _____ Results: _____
- ☐ Semen Analysis When: _____ Results: _____
- ☐ Hormone Testing When: _____ Results: _____

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

_____

_____