Center for Reproductive Care
MARY WOOD MOLO, MD

Date: _____

Trans Male 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 using your eggs? --
Are you using your uterus? --
Are you using your partners sperm or eggs? --

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: _____

Allergies (Please List): _____
Current Prescription Medication: _____

Have you used hormones for gender identity purposes? --

If so, which type:

_____

Current Over-The-Counter Medication: _____

_____

Current Herbal Supplements/Medication: _____

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

- ☐ Anemia
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Prolonged Fever
- ☐ Congenital disease
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Breast Lump
- ☐ Psychiatric Disorder
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Inguinal Hernia
- ☐ Tubal Infection
- ☐ Cystitis
- ☐ Tumor
- ☐ Epilepsy

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

_____

_____

Surgical History

What previous surgeries or biopsies have you had performed?

- ☐ Laparoscopy
- ☐ Hysteroscopy
- ☐ Abdominal Surgery
- ☐ Myomectomy
- ☐ Pelvic Surgery
- ☐ Top Surgery
- ☐ Bottom Surgery
- ☐ Removal of Ovaries
- ☐ Hysterectomy
- ☐ Gender Confirming Surgery

If you checked yes to any of the procedures, or if you have had other procedures or biopsies performed that are not listed, please elaborate: _____

_____

_____

Menstrual and Pregnancy History

Age at first menstruation: _____ Comments: _____
Age first noted breast development: _____ Comments: _____
Age first noted pubic hair: _____ Comments: _____
Age first noted axillary hair: _____ Comments: _____

Menstrual Cycles:

Do you still have menstrual cycles? --

Pregnancy History:

Have you ever been pregnant: -- (If yes, see below)

Were there any complications during or after your pregnancies? --

If yes, explain: _____

	Year	Abortion?	Miscarriage?	Ectopic?	Treatment Required?	How long to Conceive?	Live Birth?	Current Partner Father?
1st Pregnancy								
2nd Pregnancy								
3rd Pregnancy								

Sexual and Contraceptive History

What form of contraception do you use, or have you used in the past?

- ☐ Oral Contraceptive, Name: _____
- ☐ IUD, Name: _____
- ☐ Diaphragm
- ☐ Depo-Provera
- ☐ Withdrawal
- ☐ Condoms
- ☐ Tubal Ligation

For each contraceptive method, please specify duration of use:

_____

_____

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

_____

_____

Sexual History:

Frequency per month: _____ Difficulties: _____

Pain or Discomfort? _____

Marital History:

Number of years: _____ Date of marriage: _____

Number of children: _____ Number of adopted children: _____

Infertility? _____ If yes, for how long: _____

Family History

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

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Breast/Ovarian 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
- ☐ Menstrual problems
- ☐ Infertility
- ☐ Fragile X

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

_____

_____

Fertility Treatment History

Have you had any previous fertility treatment? --

If yes, who was your physician? _____

Was a specific diagnosis identified? _____

Have you cryopreserved (frozen) your oocytes? --

What medications, if any, have you taken for treatment? Check all that apply:

- ☐ Clomiphene citrate (Clomid)
- ☐ Letrozole
- ☐ FSH (Follistim, Gonal F)
- ☐ HCG (Pregnyl, Novarel, Ovidrel)
- ☐ Progesterone
- ☐ Antibiotics
- ☐ Ganirelix/Cetrotide
- ☐ hMG (Menopur)
- ☐ Prednisone
- ☐ Estrogen
- ☐ Lupron
- ☐ Metformin
- ☐ Other: specify _____

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

- ☐ Hormone tests — When: _____ Results: _____
- ☐ Endometrial Biopsy — When: _____ Results: _____
- ☐ Hysterosalpingogram (HSG) — When: _____ Results: _____
- ☐ Ultrasound/Sonogram — When: _____ Results: _____
- ☐ Intrauterine Insemination (IUI) — When: _____ Results: _____
- ☐ In Vitro Fertilization (IVF) — When: _____ Results: _____

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

_____