THE UROLOGY GROUP
Advanced Care. Improving Lives.

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Phone: (513) 841-7400
Fax: (513) 841-7501

Office Instructions for New Patients

Your appointment has been scheduled for _____ at ___:___ AM/PM

Our goals are to:

1) Provide you with the highest quality of medical evaluation and treatment to help you and your partner to achieve your reproductive goals.
2) Evaluate for potentially dangerous medical problems, which can be associated with decreased male fertility.

Prior Testing

Reports of prior semen and fertility-related blood testing are very important to assessing your fertility situation. If you have not had updated semen analysis and blood hormone testing (within the past 6 months), our office will be coordinating with you to get this testing completed prior to your upcoming appointment. The results of any new testing will be faxed to our office.

For prior testing that you have had completed in the past, please obtain copies of these results from either the lab where they were performed or from the office of the medical provider who initially ordered them. These reports must be **hand-carried** by you to your appointment. Relying on other physicians' offices to fax over reports (without hand-carrying a copy yourself) may result in that information not being available at the time of your consultation with Dr. Schwartz.

New Test Results

Unless otherwise specified, results from all new testing ordered at your initial office visit will be reviewed at a follow-up appointment. Some routine blood testing can sometimes be reported with a phone message. However, most testing, including semen analyses reports, are **typically not reviewed over the phone** prior to your scheduled follow-up appointment unless an urgent medical condition is uncovered, or prior arrangements have been made with Dr. Schwartz.

Insurance

Not all insurance policies cover infertility. Please call your insurance company to verify this benefit. If it is not covered, please be prepared to bring $200 to your first appointment. If additional treatment is needed, you will be responsible for payment.

Other Phone Calls

1) Medical emergencies associated with your fertility treatments should be managed by calling 911 or going to the nearest emergency room.
2) Other patient questions, including prescription refills, should be directed to 513-841-7400.

For prescription refills, please report the dosage of medication, if you prefer 30 or 90 day supplies with refills, and the phone number of your pharmacy.

We hope that this information is helpful, and we look forward to helping you to achieve your reproductive goals.

Male Reproductive Questionnaire

Date ___/___/____

Last Name_____ First Name_____ MI_____

Patient's Primary Care Physician: _____

General Information

Birthdate: ___/_____/_____ Age: _____ yrs. Occupation:

_____

Marital status: _____Single _____Married _____Divorced

How did you hear about the Infertility clinic? (please circle)

1) Referral from a physician (physician's name: _____)
2) Internet
3) Other: _____

Allergies

Are you allergic to any medications? Yes / No
(If yes, please name them: _____)

Do you have a history of fainting/passing out easily? Yes / No

Do you need to take antibiotics for a heart valve or prosthesis prior to procedures such as teeth cleaning, surgeries, etc. Yes / No

Do you have any history of problems with blood clots or excessive bleeding? Yes / No

Social History

Do you smoke either currently or within the past year? Yes / No
1) If yes, approximately how many years have you smoked? ___ yrs.
2) Approximately how many packs a day did/do you smoke? ___ packs
3) If you quit, approximately how long ago did you stop smoking? ___ yrs.

Do you currently use any other form of tobacco? Yes / No

Do you drink alcohol? Yes / No
-If yes, approximately how many drinks per week? _____drinks
-If no, any significant prior use of alcohol? Yes / No

Any other drug use in the past 6 months? (e.g. marijuana, cocaine, etc.) Yes / No

Hours per week of exercise: ____ hrs.

Bike riding of more than 25 miles per week? Yes / No

Sexual History

On average, how frequently do you have intercourse? _____ times per month.

Have you attempted to time intercourse with ovulation? Yes / No

If yes, what method of ovulation timing was used? _____

Do you have problems getting or maintaining an erection? Yes / No

if yes, please specify the problem and any treatments used: _____

_____

Do you use any form of lubrication? Yes / No

If yes, please specify what type used: _____

Have you noticed any significant change in sexual desire/drive? Yes / No

If yes, please specify: _____

Have you noticed any changes in the volume/color/consistency of your ejaculate? Yes / No

If yes, please specify: _____

Any other sexual-related problems? _____

Reproductive History

Trying to achieve pregnancy for approximately _____ period of time.

Most recent birth control methods and dates discontinued: _____

With **current** spouse/partner:

Number of prior pregnancies: _____

Live births: _____ Miscarriages: _____ Elective abortions: _____

Any problem initiating those pregnancies: Yes / No / Not applicable

With any **other** partners (**NOT** including current spouse/partner):

Number of prior pregnancies: _____

Live births: _____ Miscarriages: _____ Elective abortions: _____

Any problem initiating those pregnancies: Yes / No / Not applicable

Are you adopted? Yes / No

if No, is there any family history of any male relations with:

a) Difficulty conceiving? (If yes, relation to you: _____) Yes / No

b) Cystic fibrosis (male or female relatives)? (If yes, relation to you: _____) Yes / No

Have you ever had any of the following (Yes/No):

a) Vasectomy (If yes, approximate age: ___) Yes / No

b) Vasectomy reversal (If yes, approximate age: ___) Yes / No

c) Varicocele repair (If yes, approximate age: ___) Yes / No

d) Other testicular/scrotal surgery (If yes, approximate age: ___) Yes / No

e) Inguinal hernia operation (If yes, approximate age: ___) Yes / No

If yes, side of repair: Left ___ Right ___ Both ___

f) History of undescended testicle at birth? Yes / No

If yes, was it repaired Yes / No (age repaired ___yrs.)

g) History of mumps after puberty? Yes / No

If yes, age ____yrs.)

h) Recent fever >101.5°F within the last 3 months? Yes / No

i) Trauma to your testicles requiring you to seek medical attention? Yes / No

j) Hot tubs, hot baths, hot showers, saunas in last 6 months? (if Yes, circle which) Yes / No

k) Do you every use a laptop directly on your lap (last 6 months)? Yes / No

l) Significant heat or radiation exposure at work in last 6 months? Yes / No

m) Eat soy products on a daily basis (e.g. soy protein, soymilk)? Yes / No

n) Have you ever taken steroids for weight-lifting or weight loss? Yes / No

o) Do you carry a cell phone in your pants pocket (last 6 months)? Yes / No

p) Any recent significant weight gains or losses? Yes / No

q) Any recent significant changes in energy? Yes / No

r) Do you sit a lot at work? Yes / No

Have you ever had a personal history of:

a) Cystic fibrosis? Yes / No

b) Urinary tract infection? Yes / No

c) Prostate infection? Yes / No

d) Infection of the testicles or epididymis? Yes / No

e) Blood in your urine / ejaculate/semen? Yes / No

f) Have you ever had a venereal disease? If yes, indicate type: _____ Yes / No

h) Penis, bladder, prostate surgery? (other than circumcision) Yes / No

i) Chemotherapy or radiation therapy? Yes / No

j) Regular exposure to chemicals, solvents and their fumes, or any toxins/poisons within the last 6 months? Yes / No

Female Partner/Spouse Information

Name: _____

Birthdate: _____/_____/_____ Age: _____yrs. Occupation: _____

ObGyn Physician ***(fill out only if different from male partner's referring physician)***

Name: _____

Address: _____City_____ State ____ ZIP _____

General Medical Information of Female Partner

Significant medical problems/illnesses (e.g. Diabetes) - please list: _____

_____

Medications: _____

Reproductive History of Female Partner

Do you have regular menstrual cycles/periods? Yes / No

Previous pregnancies with any other partners (current spouse NOT included):

Number of pregnancies: _____

Any problem initiating those pregnancies: Yes / No / Not applicable

Live births: _____ Miscarriages: _____ Elective abortions: _____

History of gynecologic problems (e.g. Fibroids)- please list: _____
_____

Prior gynecologic surgeries- please list: _____
_____

Female Reproductive Testing

1) Ultrasounds - Has your spouse/partner had this done? Yes / No / Unsure
   If yes, year performed: _____ Result: Normal___ Abnormal___
2) Hysterosalpingogram or Saline hysterosonogram (to make sure fallopian tubes open)
   Has your spouse had this done? Yes / No / Unsure
   If yes, year performed: _____ Result: Normal___ Abnormal___
3) Laparoscopy (surgery to look into abdomen with a scope)
   Has your spouse/partner had this done? Yes / No / Unsure
   If yes, year performed: _____ Result: Normal___ Abnormal___
4) Hormone evaluation - Has your spouse/partner had this done? Yes / No / Unsure
   If yes, year performed: _____ Result: Normal___ Abnormal___
5) Other: _____
   If yes, year performed: _____ Result: Normal___ Abnormal___

Other testing planned from the female side: _____ None / Unknown

Prior Reproductive Treatments of Patient and Female Partner

1) Timing of intercourse + Medications (such as Clomid, Femara, etc.)	# cycles_____	years_____
2) Intrauterine inseminations without medications	# cycles_____	years_____
3) Intrauterine inseminations + Medications (such as Clomid, etc.)	# cycles_____	years_____
4) Standard In-Vitro Fertilization/ICSI	# cycles_____	years_____
5) IVF/ICSI	# cycles_____	years_____

I have filled out this questionnaire to the best of my knowledge. I have also received, read, and understood the 'Office Instruction Manual for New Patients'

_____ _____
Patient signature Date

I have reviewed all the patient information in detail with the patient.

_____ _____
Physician signature Date

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PLEASE COMPLETE PRIOR TO YOUR APPOINTMENT

Optimizing Your Male Fertility Potential

In anticipation of your upcoming appointment, we ask that you take 20-30 minutes to review some basic steps that you can take to maximize the quality of your sperm.

Step 1: Please visit the "Additional Resources" section of our male infertility website at: http://urologygroup.com/conditions-we-treat/male-infertility

Step 2: Click on the link that says: **CLICK HERE to visit Dr. Shane Russell's website to view "Sperm Boot Camp" information.**

Step 3: At the top of the website, select *Sperm Boot Camp/Sperm Boot Camp Intro*

This is a self-directed guide on optimizing the environment for sperm production, including:

- Lifestyle changes
- Over-the-counter antioxidants
- Tips on optimizing natural intercourse

Step 4: Please print out and complete the *Personal Fertility Profile* toward the bottom of the Sperm Boot Camp page. This will serve as a guide as to the particular lifestyle-related risk factors that may be pertinent to you, as well as the accompanying Sperm Boot Camp website sections that can help to effectively address them.

Step 5: Please bring a copy of your *Personal Fertility Profile* with you to your appointment with Dr. Schwartz so that he can see which lifestyle-related areas you are working on.

Thank you and we look forward to helping you to achieve your fertility goals.