

MALE FERTILITY INTAKE

Name _____

Date of Birth _____

How long trying to conceive? _____

Any children? _____

Have you had a fertility workup? _____

Sperm: Mobility _____ Morphology _____ Quantity _____

Other issues affecting fertility _____

Any sexually transmitted diseases? _____

Sexual desire - High Medium Low Very low

Do you exercise regularly? _____

If so, what do you like to do for exercise and how often?

Do you have a good outlet for stress? If so, what?

Do you feel your stress level is high? _____

What medications are you taking?

What vitamins or supplements are you taking?

Do you eat a well balanced diet? Always Sometimes Occasionally Never

Do you eat breakfast? Always Sometimes Occasionally Never

Do you sleep well? _____ How many hours on average a night? _____

Do you smoke? _____ How often? _____

Do you drink alcohol? _____ How often? _____

Do you drink coffee / caffeine drinks? _____ How often? _____

Do you use recreational drugs? _____ What? _____

How often? _____

Do you regularly go in hotubs or saunas? _____

Do you have a well balanced diet? _____