

Male Pre-Conception Health Questionnaire

These questions have been designed to give a clear picture of your present health status and to identify any potential health problems for the future. All your answers are confidential and will only be seen by the health assessor. However, should a significant health problem be detected requiring medical investigation, you will be given a letter to take to your GP.

You should receive a summary within seven to ten days of your assessment. If you give your e-mail address, your summary will be sent electronically.

Name:	Date of Birth:
Address:	Tel No:
E-mail:	GP Name & Address:
Occupation:	Hours of work per week:

Personal Medical History

*Please put for YES and for NO. Leave blank if unsure.
If you answer YES, please give brief details in Supplementary Information section.*

1) Do you or have you ever suffered from any of the following cardiovascular diseases or disorders?

Heart Attack <input type="checkbox"/>	Angina <input type="checkbox"/>	Recurrent Chest Pain <input type="checkbox"/>	Palpitations <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>
Heart Murmur <input type="checkbox"/>	Rheumatic Fever <input type="checkbox"/>	Irregular Pulse <input type="checkbox"/>	Valve Disease <input type="checkbox"/>	

2) Do you or have you ever suffered from any of the following diseases or disorders of the brain?

Stroke <input type="checkbox"/>	Dizziness <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Convulsions <input type="checkbox"/>
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3) Do you or have you ever suffered from any of the following nervous disorders?

Anxiety <input type="checkbox"/>	Depression <input type="checkbox"/>	Stress <input type="checkbox"/>
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4) Do you or have you ever suffered from any of the following respiratory diseases or disorders?

Asthma Chronic Bronchitis Tuberculosis Coughing Up Blood

5) Do you or have you ever suffered from any disease or disorder of the following genito-urinary organs?

Kidneys Bladder (eg cystitis)

6) Do you or have you ever suffered from any of the following diseases or disorders of the digestive system?

Peptic Ulcer Recurrent Diarrhoea Recurrent Constipation Rectal Bleeding

Ulcerative Colitis Crohn's Disease Irritable Bowel Syndrome

7) Do you or have you ever suffered from any of the following liver disorders?

Jaundice Hepatitis Cirrhosis

8) Do you or have you ever suffered from any of the following diseases or disorders of the muscles or joints?

Slipped Disc Osteoarthritis Rheumatoid Arthritis Gout

9) Do you or have you ever suffered from any of the following endocrine conditions?

Diabetes Type 1 Diabetes Type 2 Glandular Disease Thyroid Disorder

10) Do you or have you ever suffered from any disease or disorder of the following?

Skin Eyes Ears Nose Throat Mouth

11) Have you ever been diagnosed as having any form of the following?

Cancer Tumour Cyst Lump

If yes, where in the body?

12) Have you ever suffered from any of the following blood disorders?

Anaemia

Leukaemia

13) Do you suffer from any of the following progressive debilitating diseases?

Multiple Sclerosis

Parkinson's Disease

Muscular Dystrophy

14) Have you ever undergone any of the following investigations (excluding pregnancy)?

Xray

ECG

CT Scan

MRI Scan

Ultrasound

Blood Test

15) Have you ever undergone a surgical operation? If yes, give details below

16) Have you ever suffered from any serious injury requiring hospital treatment?

17) Have you ever received treatment from a Complementary Health Practitioner?

Supplementary Information	
<i>Please insert question number and relevant details in the space provided</i>	
Question Number	Brief Details ie. condition, dates, investigations, duration of treatment etc

Genito-Urinary History

Do you routinely examine your testicles for lumps ?

Have you ever noticed a lump? If yes, did you seek medical advice?

What was the outcome?

Do you need to pass urine during the night? Rarely Occasionally Regularly

How often during the night do you need to get up to pass urine?

Do you sometimes have difficulty passing urine?

Have you ever noticed blood in your urine?

Have you ever been treated for a sexually transmitted disease

If yes, what was the name of the disease(s)?

Do you ever suffer from erectile dysfunction (impotence)?

If yes, have you received treatment for this?

Have you ever had a test to check your sperm count?

Have you had a blood test for toxic heavy metals?

Have you ever had a Hair Mineral Analysis for toxic metals and mineral ratios?

Have you ever had a male hormone profile blood test?

Medication: Please state the medicines you are currently taking

Name of Medicine	Dosage	Times taken per day
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.....
.....

Nutritional or Herbal Supplements: Please state any you are currently taking

Name of Supplement	Dosage	Times taken per day
.....
.....
.....

Allergies or Intolerances:

Do you suffer from any allergies?

If yes, what are you allergic to?

Has your allergy been confirmed by a specialist or test?

Do you suffer from any food intolerances?

If yes, what are you intolerant to?

Has your intolerance been confirmed by a specialist or test?

Smoking Status:

Do you smoke? If yes, please state Cigarettes Cigars Pipe Other

How many a day? Do you intend to give up smoking soon?

If you do not smoke now, have you ever smoked?

If yes, please state Cigarettes Cigars Pipe Other

When did you stop smoking?

Alcohol Status:

One unit = 1/2 pint of Beer/Cider, a small glass of wine, or a pub measure of spirits

What is your average weekly consumption of alcohol in units?

If <1, how many units a month? Did you regularly drink more in the past?

Do you drink more than 3 units a day? Never Occasionally x1/week or more Every Day

Dietary History:Do you eat at least 3 meals a day?

If not, which meal(s) do you miss?

Do you eat at least 5 portions of fruit and vegetables a day? Do you eat meat? Do you eat fish? Are you a Vegetarian/Vegan? Do you include roughage (high fibre foods) in your diet? Do you eat convenience/processed food and takeaways?

	<1 a week	1-2 x a week	3-6 x a week	Every day
If yes, how often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Regularly	Occasionally	Never

Do you eat organic produce? Do you usually add sugar to beverages or breakfast cereals? Do you use artificial sweeteners? If so, which brand?How many glasses of water do you drink a day? Do you drink tap water? Is your water fluoridated? Do you use a water filter? How many glasses of fruit juice do you drink a day? Do you drink caffeinated tea or coffee? No. of cups of tea Cups of coffee Do you drink fizzy drinks? How many a week? Do you drink diet versions? **Exercise:**Do you have a regular exercise routine? Do you do at least ½ hour of brisk exercise five times a week?

If not, how much exercise do you do in a week?

What type(s) of exercise/activity do you do?

Do you have a sedentary job? Do you often drive short distances rather than walk? Do you normally take the lift or escalator rather than the stairs? Do you have a disability that prevents you from exercising? Do you find time to relax each day?

Dental History:

When did you last visit a dentist?

Do you have mercury fillings?

Do you suffer from mouth ulcers? If yes, how often? Occasionally Regularly

Do you use a toothpaste containing fluoride?

Do you use a mouthwash containing alcohol?

Chemical Exposure:

Do your toiletries contain any of the following ingredients?

Sodium Lauryl Sulphate	Sodium Laureth Sulphate	Propylene Glycol	DEA / TEA / MEA
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talc	Isopropyl	DMDM hydantoin	Imidazolidinyl urea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Aluminium	Butylated hydroxytoluene
		<input type="checkbox"/>	<input type="checkbox"/>

Do you use air fresheners (any type)?

Do you use supermarket or main brands of household cleaning products?

Family History:

Have close members of your family suffered from any of the following diseases or disorders?
Please put **M** for mother, **F** for father, **S** for sister or **B** for brother.

Diabetes Type 1 (Insulin dependent) Diabetes Type 2 (Non-Insulin dependent)

Stroke Heart Attack High Blood Pressure High Cholesterol

Osteo-arthritis Rheumatoid Arthritis Osteoporosis

Alzheimer's Disease Kidney Disease Respiratory Disease

Glaucoma Cancer If yes, where is/was the cancer?

Are both your parents still alive? If no, what age did they die? **M** **F**

What caused their death?

M

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F

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