This form must accompany **ALL** semen samples

Name (Forename and Surname)	
Date of Birth	
Name of Partner (full name, only if applicable)	
Address	
Referring Doctor/Practitioner	
When is your **next appointment** booked with your doctor/practitioner (date and time)	
Date of vasectomy (if applicable)	
Date of semen test	
Appointment time	
Have you had a semen test here before?	
When did you last ejaculate?	

It is essential that you answer all of the following questions:

How did you book you appointment, please tick appropriate box Online ☐ Email ☐ Telephone ☐ Clinic Walk-in ☐	
Have you been unwell during the last 3 months? If so please explain	
Have you had a **fever** in the last 3 months?	
Please list any medication that you are currently taking	
What **time** did you produce this sample?	
Did you get the **entire** sample into the container? (yes or no)	
Did you have any difficulty in producing the sample? (yes or no)	

After you have produced the sample, please make sure the lid is secure on the sample container and clearly labelled.

It is important that the test we do for you is reliable. To do this, we need to use random samples each day to accuracy check our equipment. Additionally, we are trying to improve testing for male infertility, for example, measuring free radicals and zinc levels in semen which can affect fertility. Please help us, by providing your permission to use any remainder of your sample for these purposes. Be assured that this will NOT compromise your sperm analysis in any way and that the samples will not be used for any other purpose and discarded immediately after.

I DO/DO NOT give my permission to use any remains of my sample for testing (delete as appropriate)

Signed……

	ADDITIONAL INFORMATION		
How long have you been trying to conceive?			
Do you have children? If so, what age is the youngest?	YES	NO	
Do you smoke? If so how many per day?	YES	NO	
Are you exposed to chemicals (work or hobbies)? If so, which?	YES	NO	
Do you go cycling / spinning? If so state which and for how many miles per week.	YES	NO	
Do you run? If so, how many miles per week?	YES	NO	
Have you run marathons / triathlons?	YES	NO	
Do you do any other form of exercise? If so, which and for how long?	YES	NO	
Do you sit for long periods? (drive for long periods?)	YES	NO	
Do you take: Hot baths/saunas/Jacuzzis/steam baths?	YES	NO	
Do you drink alcohol? If so, how many units per week?	YES	NO	
Do you binge drink?	YES	NO	
Do you drink caffeinated drinks? If so, how many cups per day?	YES	NO	
Do you drink Coca-Cola or similar? If so, how many cans per week?	YES	NO	
Are you taking any supplements or steroids? If so, which ones?	YES	NO	
Are you taking any drugs (prescription or recreational)? If so, please specify	YES	NO	
Do you have any medical conditions? If so please specify	YES	NO	
Do you have a varicocoele? If so, please specify	YES	NO	
Have you had any surgery to the testes? If so, please specify	YES	NO	
Have you had any trauma to the testes? If so, please specify	YES	NO	
Have you had any sexually transmitted infections? If so, please specify	YES	NO	
Are you on a specific diet (vegan, vegetarian, pescatarian, etc.)? If so, please specify	YES	NO	
Do you eat fast food? If so, how many times a week?	YES	NO	
Are there any other factors that you think might have an impact on your fertility? If so please specify	YES	NO	