Subject ID # _____

Choline dehydrogenase and sperm motility in men

Medical History Questionnaire

Name _____ Date _____

Date of birth _____ Marital Status _____ Number of children_____

Were any of your children conceived using assisted reproductive technology due to male factor infertility? Yes / No

Have you ever been diagnosed with a fertility problem? Yes / No

If "yes" please circle all that apply:

Low sperm count Low sperm motility Increased semen viscosity

Decreased semen viscosity Abnormal sperm shape Increased semen volume

Decreased semen volume Abnormal semen pH Abnormal liquefaction time

Abnormal number of white blood cells in semen

Other, please explain _____

_____

Were you ever treated for a fertility problem? Yes / No

If "yes", please describe treatment: _____

_____

Was your condition improved with treatment? Yes / No

Do you have male family members with fertility problems? Yes / No

If "yes", what is their relationship to you (brother, father, etc)? _____

Are you currently taking any medication? If "yes", please specify. _____

_____

Are you taking any medication known to alter fertility or sperm function? Yes / No

Please specify. _____

Are you currently being treated for a medical condition? Yes / No

If "yes", please specify. _____

_____

Do you have a chronic medical condition? Yes / No

If "yes", please specify_____