DONOR EGGS AUSTRALIA
DONOR EGGS AUSTRALIA PTY LTD
ABN 25627752783

Dr Joel Bernstein
MB ChB (Rand) BSc (Wits) FRCOG FRANZCOG

Nikki Fine
Donor Coordinator and Ultrasonographer
M: 0416 161 442
E: nikki@donoreggsaustralia.com.au

Denyse Asher
Donor Coordinator and Scientist
M: 0411 386 131
E: denyseb@donoreggsaustralia.com.au

Donor Eggs Australia

MALE HISTORY

Introduction

1. The following information has been requested by the respective overseas donor egg/sperm/embryo Clinics for your preparation for their programmes and will be transmitted to them.

2. Please make every attempt to be as accurate and comprehensive as possible.

3. Where blood results, scan reports, Genetic Tests are requested copies or originals of tests need to be provided. If the test is out of date or needs to be repeated you will be informed and appropriate test request forms will be provided by Donor Eggs Australia.

4. Please use Black Ink only to fill out the forms.

4. When filling in the form please cross Yes or No answers and if a number is required,even if zero, please fill in a zero rather than leaving blank. *Examples are in Italics*.

5. Please post or email your completed forms to the address below.

6. Nikki and Denyse have their mobiles and e-mail on the letterhead above R.

Postal Address

Donor Eggs Australia
52 Gilgandra Road
North Bondi
Sydney
NSW
2026

MALE INFORMATION

Identification

Surname	
First & Middle Names	
Date of birth	Day Month Year
Current Age	
Country of birth	
Country of present residence	
Occupation	
Telephone Home	
Work	
Mobile	
E mail	
Passport Nationality	
Passport Number	

Physical Characteristics

Racial Group	
Eye colour	
Hair colour	
Height (cm)	
Weight (Kg)	
Blood Group	
Rh	

MALE FERTILITY CONSULTATION

GENERAL HISTORY

Illnesses:

Do you suffer from any disease of the heart, lungs, intestinal tract, kidneys, bladder, immune system, nervous system or other any other system? Yes No

Do you suffer from any type of endocrine disease? Yes No
(Diseases affecting the thyroid, parathyroid, adrenal or pituitary glands?)

Have you suffered from any tropical diseases e.g. malaria? Yes No

Have you suffered from TB (tuberculosis)? Yes No

Please fill in the name/nature of the illness (s)?

		Treatment	
	Type/nature of Illness	Yes	No
1			
2			
3			
4			

Allergies:

Are you allergic to any form of medication? Yes No
Please list the medication(s):

Please fill in the name(s) of the medication you are allergic to. Use the generic names where possible i.e. the actual drug name rather than the trade name.

Birth Defects:

Were you born with any birth defects or abnormalities? Yes No

Please describe below:

Do you have congenital absence of the vas (CAVD)? Yes No

(The vas deferens is the tube connecting the testis which runs from the testis to the base of the penis, and transports sperm. In the above condition{CAVD} the vas fails to develop).

CURRENT MEDICATION

Are you taking any form of medication at present? Yes No

Please fill in the name(s) of the medication you take. Use the generic names where possible i.e. the actual drug name rather than the trade name.

Have you taken any form of steroids? Yes No

Whether for body building or not. If so please include in the list above.

Are you taking any form of herbal medicine or vitamins? Yes No

If yes

Does it contain Gingko, St John's wort or Echinacea? Yes No

SURGICAL HISTORY

Have you ever had any type of operation or surgical procedure from the time you were born up till the present time? Yes No

If no please proceed to the next question.

If yes:

Date	Type of Operation

I have included a list some of the more relevant operations, which include:

Herniorrhaphy *operation performed on weaknesses of the abdominal wall called hernias. These include femoral and inguinal hernias, and may be called direct or indirect hernias.*

Orchidopexy / Correction of undescended testes.
The testis normally descend into the scrotum after birth but in some males this fails to happen and requires surgical correction.

Varicocoelectomy / Surgery for a varicocoele
Surgery to correct abnormal or varicose veins around the testis.

Sterilisation or vasectomy *a surgical procedure to cut the vas deferens to make the male sterile for permanent contraception/family planning.*

Vasectomy reversal
To attempt reversing the effects of vasectomy

Laparotomy *an operation in the abdominal or pelvic cavity performed through a cut in the abdominal wall*

Appendicectomy *removal of the appendix*

Orchidectomy *surgery to remove a testis.*

Prostatectomy *surgical removal of some or part of the prostate gland.*

Cancer surgery *for cancer anywhere on the body.*

Removal of a testicular cyst or tumour of the testis
Removal of a testis / orchidectomy
Usually performed to remove damaged testis of for testicular cancer.

FAMILY HISTORY

Have any of your children had birth defects/congenital abnormalities? Yes No

Male	Female	Type of Birth Defect

Has anyone in your family had children with birth defects congenital abnormalities? Yes No

If yes please supply details including their relationship to you, e.g. brother, sister or cousin.

Relationship	Birth Defect

Has anyone had a stillbirth or child who died in the first few weeks after birth? Yes No

Have any members of your family on both your mother and/or father's side had cancer of the ovary or breast ? Yes No

Have any members of your family suffered with Non insulin dependent diabetes, (NIDDM) *(Type 2 diabetes, or late onset / adult onset diabetes)*? Yes No

Have any members of your family suffered with infertility? Yes No

What are their relationships with you? (Brothers, Sisters):

Brother	Sister	Cause of infertility if it is Known

GENERAL & SOCIAL HISTORY

What is your occupation?

Has your occupation brought you into long term contact with toxic chemicals, ionising radiation or microwave irradiation? Yes No

If yes or you are unsure please describe anyway:

Do you smoke tobacco in any form? Yes No

Do you smoke marijuana? Yes No

Do you take any habit-forming drugs? Yes No

Do you drink alcohol? Yes No

If yes:

Amount	Per day	Per week
Wine glasses		
Beer glasses		
Spirits tots		

Do you perform any exercise over and above that required by your daily home or work routines or duties? Yes No

If yes:

30 Minute Sessions

Less than 3 times per week	
3 times per week	
More than 3 times per week	

FERTILITY

Have you had mumps ? Yes No

A contagious viral disease usually affecting the salivary glands causing swelling below and behind the ears and sometimes the testicles.

If yes how old were you when you had the mumps? Years

Did it affect your testicles causing pain and swelling? Yes No

Did you have to have an operation to relieve the swelling? Yes No

Have you had any injury to the testicles, which led to severe swelling of the testicles? Yes No

Did you have an operation to relieve the swelling? Yes No

Between birth and now have you ever suffered with undescended testis? Yes No

Testis missing from your scrotum, either permanently or temporarily.

At present are there any abnormal swellings or growths in your scrotum? Yes No

Do you have a varicocoele? Yes No

This is an abnormal collection of veins in the scrotum causing a swelling Feels like a bag of worms.

Has this been treated? Yes No

Have you ever suffered from a sexually transmitted diseases or infection? Yes No

If yes:

	Yes	No
Gonorrhoea		
Syphilis		
Chlamydia		
Herpes		
HIV / AIDS		

Have you ever suffered from a discharge from the penis? Yes No

Have you ever suffered from ongoing pain in the testicles Yes No

PREGNANCIES

Have you achieved any pregnancies with your current partner? Yes No

Have you achieved any pregnancies with another partner? Yes No

Outcome of pregnancies with another partner?

PREGNANCY	NUMBER
Miscarriage	
Termination of pregnancy	
Live child	

Have you ever had an abnormal sperm count or test? Yes No

Please provide details below:

Have you ever been diagnosed with infertility? Yes No

Please provide details below:

SEXUAL INTERCOURSE

How often do you have sex per week on average?

Less than 1	
1 to 2	
2 to 3	
3 to 4	
More than 4	

Do you have problems having an erection for sex? Yes No

If yes, do you need medication to obtain an erection? Yes No

Can you have an erection for masturbation? Yes No

Do you have problems ejaculating? Yes No

Ejaculation is the release of sperm from the penis.

Does this problem occur with sexual intercourse? Yes No

During sexual intercourse do you ejaculate? Always

Occasionally

Never

Can you ejaculate with masturbation? Yes No

Have you sought help for these problems? Yes No

Was the help successful? Yes No

Have you ever had to freeze your sperm? Yes No

If yes please give the reason for this:

FERTILITY AND OTHER TESTS

- BLOOD TESTS

These include hormone levels, full blood count and chemistry, infection screen for Hepatitis A, B & C, HIV and HTLV, Chlamydia, Syphilis, Gonorrhoea, chromosomes/karyotype, DAZ gene tests, cystic fibrosis, and antisperm antibody tests.

PLEASE ATTACH COPIES OF ALL BLOOD TESTS PERFORMED IN THE LAST YEAR. If in doubt attach results!

- SEMEN ANALYSIS INCLUDING SPERM DNA FRAGMENTATION TESTS

Please include copies of all sperm tests performed in the last 2 years.

- REPORTS OF SURGICAL PROCEDURES AND ASSOCIATED PATHOLOGY TESTS

- ADDITIONAL REPORTS OF ULTRASOUNDS, CT SCANS

Any additional information that you feel is relevant:

Donor Eggs Australia

Summary of Male Patient Information

Photograph

Please email one current photo of both you and your partner and children if available to denyseb@donoreggsaustralia.com.au

The file size should not exceed 250Kb

Disclaimer

The information that you have provided is to the best of your knowledge accurate and up to date. In Australia this information is dealt with within the dictates of the Privacy Act. This information is being transmitted to the relevant clinic and neither Donor Eggs Australia or its professional associates can be held responsible for this information once transmitted or stored overseas.

Signature **Name**

Date

Checklist:

Forms Completed and Signed	**Photo sent**	**Copies of tests, results and outcomes included**

52 Gilgandra Road l North Bondi l Sydney l NSW l 2026 l Australia
Fax: 029343-4015
www.donoreggsaustralia.com.au
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