MEN'S ENTRANCE QUESTIONNAIRE
Natural Procreative Technology (NPT, Evaluation and Surveillance of Treatment for Infertility or Miscarriage

The Purpose of the Study and Men's Entrance Questionnaire

This questionnaire is part of the ongoing study to assess live birth rates among those who consider or receive Natural Procreative Technology (NPT,) treatment to conceive or maintain pregnancy. The purpose of the research is to understand the use of NPT, and characteristics that may help us predict how successful NPT will be for each couple for infertility or miscarriage.

The information you provide is important to this study, whether or not you actually get treatment with NPT, and regardless of when you begin treatment with NPT.

Your NPT physician, Dr. Yeung, is a participating Investigator in this study. All information is completely confidential. You will not be identified in the results reported from this study.

We estimate that this questionnaire will take about 45 minutes to complete for most men.

In addition to this questionnaire, there is a **men's medical records release form.**

Instructions for Completing the Men's Entrance Questionnaire

Thank you for your participation in this study! We appreciate your willingness to participate in this important research. Please take your time as you answer the following questions. Think carefully and remember as best you can the information requested. Please feel free to make an estimate if you are unsure of the answer.

If you begin to tire, please take a break for a few minutes to refresh yourself. If you have difficulty with a particular topic, skip it and go to topics that are less difficult. Come back to the difficult section later.

You may skip any question you are uncomfortable answering. If you choose to skip a question, either because you don't know the answer or you prefer not to answer, please place a line through the question rather than leaving it blank. (If you leave it blank we do not know whether the question was skipped accidentally or deliberately.) If you are asked to supply a number as a response, please select a whole number. Please avoid ranges of numbers and fractions of numbers.

If you have any questions or comments or feel a question is inappropriate for your situation, please write the comment at the question or at the end of questionnaire. You may also discuss any questions or comments with your NPT physician or staff.

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NPT Technology Evaluation and Surveillance of Treatment
Men's Entrance Questionnaire

Family (Last) Name_____

Given (First) Name_____

Email address for yearly surveys_____

A. Initial Information

(A-02) What is your month and year of birth? |___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(A-03) What is your marital status? (Please mark ☒ one)
☐ Never married ☐ Married ☐ Widow ☐ Divorced

(A-05) Is this your first marriage?
☐ Yes ☐ No

B. Trying to Have a Baby

For the purposes of this questionnaire, "trying to have a baby" means having regular sexual intercourse without any contraception, whether or not you were doing anything else to try to get pregnant.

(B-06) How often is intercourse physically painful for you? (Please mark ☒ one)

Always	Often	Sometimes	Rarely	Never
☐	☐	☐	☐	☐

(B-07) How often do you have difficulty achieving or maintaining an erection? (Please mark ☒ one)

Always	Often	Sometimes	Rarely	Never
☐	☐	☐	☐	☐

(B-08) How often do you have difficulty with penetration? (Please mark ☒ one)

Always	Often	Sometimes	Rarely	Never
☐	☐	☐	☐	☐

(B-09) When you have intercourse, how often do you ejaculate inside the vagina? (Please mark ☒ one)

Always	Often	Sometimes	Rarely	Never
☐	☐	☐	☐	☐

C. Andrologic History (Male Sexual Health)

(C-01) How many sexual partners have you had over your lifetime? _____ (Number)

(C-02) Have you ever been diagnosed with Chlamydia?
☐ Yes ☐ No ☐ Unsure

(C-03) Have you ever been diagnosed with gonorrhea?
☐ Yes ☐ No ☐ Unsure

(C-04) Have you ever been diagnosed with genital warts?
☐ Yes ☐ No ☐ Unsure

(C-05) Have you ever been diagnosed with genital herpes?
☐ Yes ☐ No ☐ Unsure

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(C-06) Have you ever been diagnosed with any other sexually transmitted infection?
☐ Yes ☐ No ☐ Unsure
If yes or unsure, please describe: _____

(C-07) Have you ever been tested for any sexually transmitted infection (even if the test was negative)?
☐ Yes ☐ No ☐ Unsure

D. Family Planning History

(D-02) Have you ever used condoms?
☐ Yes ☐ No
If yes:
Over your lifetime, how long did you use or have you used condoms? _____Year(s) _____Month(s)
What is the date of your last use of condoms?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(D-03) Have you ever used any other method(s) of family planning?
☐ Yes ☐ No
If yes:
Please describe any other method(s) used? _____
Over your lifetime, how long did you use or have you used any other method(s)?
_____Year(s) _____Month(s)
What is the date of your last use of any other method(s)?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(D-04) Have you ever gotten any woman pregnant, regardless of how long ago or the outcome of the pregnancy?
☐ Yes ☐ No ☐ Unsure

E. Previous Fertility-Related Investigations

(E-01) Have you had an analysis of seminal fluid (sperm count)?
☐ Yes ☐ No

(E-02) If yes, what was the result of the most recent analysis? (Please mark ☒ one)
☐ Very abnormal ☐ Moderately abnormal ☐ Minimally abnormal ☐ Normal ☐ Unsure

(E-04) Have you been seen by an urologist?
☐ Yes ☐ No ☐ Unsure
If yes, please describe: _____

(E-05) Have you had any other investigations?
☐ Yes ☐ No
If yes, please describe: _____

F. Previous Fertility-Related Diagnoses

Please mark ☒ all of the following that you have ever been told you have or suspect you might have had:

(F-01) Undescended testicle
☐ Yes ☐ No ☐ Unsure

(F-02) Mumps
☐ Yes ☐ No ☐ Unsure

(F-03) Testicular trauma
☐ Yes ☐ No ☐ Unsure

(F-04) Varicocele (excess veins in the scrotum)
☐ Yes ☐ No ☐ Unsure

(F-05) Infection of the prostate
☐ Yes ☐ No ☐ Unsure

(F-06) Infection of the epididymis
☐ Yes ☐ No ☐ Unsure

(F-07) Infection of the testes
☐ Yes ☐ No ☐ Unsure

(F-08) Problems with orgasm/ejaculation
☐ Yes ☐ No ☐ Unsure

(F-09) Other
☐ Yes ☐ No
If yes, please specify: _____

G. Previous Fertility-Related Surgeries

(G-01) Which of the following surgeries have you had? Please include month and year of the surgery.

Yes	No	Surgery	Date of Surgery	Date of Surgery	Date of Surgery
		Circumcision			
		Vasectomy			
		Vasectomy Reversal			
		Removal or ligation of varicocele			
		Surgery on the Prostate			
		Surgery on the Penis			
		Surgery on the Testis			
		Surgery on the Epididymis			

(G-02) Have you ever had any surgery in the pelvis or reproductive organs that was not described above?
☐ Yes ☐ No
If yes, please describe: _____

(G-03) Have you ever had any other surgery anywhere in the body that was not described above?
☐ Yes ☐ No
If yes, please describe: _____

H. Previous Fertility-Related Medical Treatments

(H-02) Has your doctor or provider ever given you medication or recommended vitamins to improve your sperm?

☐ Yes ☐ No

If yes, please describe: _____

I. Experience of Past Fertility Treatment

(I-01) Have you or your partner ever been evaluated or treated for fertility problems or miscarriage in the past, not including NPT (NaPro Technology)?

☐ Yes ☐ No

→If no, please skip to Section J, Adoption; if yes, continue to question I-02.

In the next questions, please consider your overall experience with medical evaluation and treatment for infertility or miscarriage that you and your partner have had in the past (not including NPT). Please answer from your own perspective, not necessarily your partner's.

How do you assess the doctors and the staff that you have worked with?

(I-02) Did they make you feel you had enough time during the consultations? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(I-03) Did they involve you in decisions? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(I-04) Did they listen to you? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(I-05) Did they explain the purpose of examinations, tests, and treatments? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(I-06) Did they tell you what you wanted to know about the causes of infertility and/or miscarriage? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(I-07) Did they tell you what you wanted to know about the treatment of infertility and/or miscarriage? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(I-08) Did they deal with emotional consequences of your infertility or miscarriage and treatment? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(I-09) Did they make a treatment plan adjusted to your special situation? (Please mark ☒ one)

Bad				Excellent	
1	2	3	4	5	Don't know/not relevant
☐	☐	☐	☐	☐	☐

(I-10) What have you liked most about you and your partner's past treatment?

_____

_____

_____

(I-11) What have you liked least about you and your partner's past treatment?

_____

_____

_____

(I-12) What is your overall satisfaction rating for you and your partner's past treatment, rated from 1-10? (Please mark ☒ one)

Not at all satisfied									Very Satisfied
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

J. Adoption

(J-01) Have you ever applied for adoption?
☐ Yes ☐ No

(J-02) Do you have any adopted children?
☐ Yes ☐ No

(J-03) Have you ever had foster children?
☐ Yes ☐ No

(J-04) Do you currently have any foster children?
☐ Yes ☐ No

K. General Health History

(K-01) Which of the following conditions have you ever had? (Please mark ☒ all that apply)

☐ Migraine headaches	☐ Anemia	☐ Urinary tract infections
☐ Varicose veins	☐ Allergies such as hay fever	☐ Allergic skin reaction
☐ Seizures	☐ Thyroid disease	☐ Rheumatoid arthritis
☐ High blood pressure	☐ Heart disease	☐ Blood clots
☐ Kidney disease	☐ Liver disease	☐ Chronic fatigue syndrome
☐ Fibromyalgia	☐ Multiple sclerosis	☐ Crohn's disease
☐ Ulcerative colitis	☐ Lupus erythematosus	☐ Sjogren's syndrome
☐ Scleroderma	☐ Frequent diarrhea	☐ Frequent constipation
☐ Non-insulin-dependent diabetes mellitus		☐ Insulin-dependent diabetes mellitus

☐ Cancer (describe): _____
☐ Hormone problems (describe): _____
☐ Other autoimmune disease (describe): _____
☐ Food intolerance (describe): _____
☐ Other medical problems (describe): _____
☐ None

(K-02) Do you have any drug allergies?
☐ Yes ☐ No
If yes, please describe: _____

(K-03) Please list all drugs, vitamins, or herbs you are currently taking on a regular basis, whether they are prescribed or over-the-counter:
_____
_____
_____

(K-04) What has been your lowest weight as an adult?
_____Pounds
or _____Kilograms

(K-05) What has been your highest weight as an adult?
_____Pounds
or _____Kilograms

(K-06) What is your current weight?
_____Pounds
or _____Kilograms

(K-07) Have you ever experienced unexplained increases in your weight?
☐ Yes ☐ No ☐ Unsure

(K-08) Have you ever experienced unexplained decreases in your weight?
☐ Yes ☐ No ☐ Unsure

(K-09) Has a medical professional ever expressed a concern about your weight?
☐ Yes ☐ No ☐ Unsure

(K-10) Have you ever had an eating disorder (such as anorexia, bulimia, or others)?
☐ Yes ☐ No

(K-11) Have you been immunized against rubella (German measles)?

☐ Yes ☐ No ☐ Unsure

In general, how much do you experience the following symptoms: (Please mark ☒ one for each)

(K-12) Fatigue

Minimal Extreme

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(K-13) Sleep Disturbance

Minimal Extreme

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(K-14) Low Mood or Feeling Depressed

Minimal Extreme

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(K-15) Anxiety

Minimal Extreme

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

The next 10 questions address potential environmental or occupational exposures. Please indicate whether you have had a significant exposure to each of these. (Please mark ☒ one for each)

(K-16) Ionizing radiation other than medical x-rays (gamma rays, x-rays, alpha and beta particles, neutrons).
☐ Yes ☐ No ☐ Unsure

(K-17) Magnetic radiation from towers (electromagnetic energy radiated or transmitted as rays or waves).
☐ Yes ☐ No ☐ Unsure

(K-18) Chemical solvents (liquid substance capable of dissolving other substances).
☐ Yes ☐ No ☐ Unsure

(K-19) High noise levels (such as jack hammering, rock concerts, headsets with high volume).
☐ Yes ☐ No ☐ Unsure

(K-20) Heavy metals (such as lead, cadmium, or mercury).
☐ Yes ☐ No ☐ Unsure

(K-21) Pesticides (chemicals used to kill insects).
☐ Yes ☐ No ☐ Unsure

(K-22) Herbicides (chemicals used to kill weeds or unwanted plants).
☐ Yes ☐ No ☐ Unsure

(K-23) Water pollution (water contaminated with sewage, chemicals, or fertilizers).
☐ Yes ☐ No ☐ Unsure

(K-24) Air pollution (smog or particular matter).
☐ Yes ☐ No ☐ Unsure

(K-25) Other
☐ Yes ☐ No ☐ Unsure

If yes, please describe: _____

L. Family History

The next few questions are about family history that might relate to your fertility.

(L-01) Does your biologic father or mother or your siblings have a history of infertility or other reproductive problems?

☐ Yes ☐ No ☐ Unsure

If yes or unsure, please describe: _____

(L-02) Which of the following conditions has your biologic mother, father, siblings, grandparents, cousins, nieces, or nephews ever had? (Please mark ☒ all that apply)

☐ Rheumatoid arthritis ☐ Multiple sclerosis ☐ Crohn's disease
☐ Ulcerative colitis ☐ Lupus erythematosus ☐ Sjogren's syndrome
☐ Scleroderma ☐ Thyroid disease ☐ Insulin-dependent diabetes mellitus
☐ Non-insulin-dependent diabetes mellitus
☐ Other autoimmune disease (describe): _____
☐ None

(L-03) Does your biologic family have genetic conditions that may be passed on?

☐ Yes ☐ No ☐ Unsure

If yes or unsure, please describe: _____

(L-04) Does your partner's biologic family have genetic conditions that may be passed on?

☐ Yes ☐ No ☐ Unsure

If yes or unsure, please describe: _____

M. Health Habits

(M-01) On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes that made you SWEAT and BREATHE HARD, such as fast walking, jogging, swimming laps, playing tennis, fast bicycling, heavy yard work or housework, or similar aerobic activities? (Please mark ☒ one)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

(M-02) On how many of the past 7 days did you exercise or participate in sports activities for at least 20 minutes but less vigorously than described above? (Please mark ☒ one)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

(M-03) Have you ever smoked cigarettes?

☐ Yes ☐ No

→If no, please skip to question M-05; if yes, continue to question M-04.

(M-04) Do you currently smoke cigarettes?

☐ Yes ☐ No

If yes, how many cigarettes do you usually smoke per day? _____

If no, in what month and year did you quit smoking cigarettes?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)

Month / **Year**

(M-05) Have you ever used tobacco in any other form (pipes, cigars, snuff, chewing tobacco, etc.)?

☐ Yes ☐ No

→If no, please skip to question M-07 below; if yes, please continue to question M-06.

(M-06) Do you currently use tobacco in some form?

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☐ Yes ☐ No

If no, in what month and year did you quit using tobacco?

|___|___|___| / |___|___|___|___| (*example:* Mar / 1985)
Month / **Year**

(M-07) On average during the last month, how many cups of coffee did you drink per **day**?
(**Do not count espresso**) (Please mark ☒ one)
☐ 0 ☐ less than 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

(M-08) On average during the last month, how many cups of espresso did you drink per **day**?
(Please mark ☒ one)
☐ 0 ☐ less than 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

(M-09) On average during the last month, how many cans or bottles of caffeinated soda drinks did you drink per **day**, including Coca Cola, Pepsi, and others? (Please mark ☒ one)
☐ 0 ☐ less than 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

(M-10) On average, how many units of alcohol do you drink per **week**? (Please mark ☒ one)
(1 unit = glass (half-pint) of beer, 1 measure of spirits, 1 small glass of wine)
☐ 0 ☐ less than 1 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

(M-11) In the last month, what is the highest number of units of alcohol you had in a **24-hour period**?
(Please mark ☒ one)
☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ 8-9 ☐ 10-12 ☐ 13-15 ☐ over 15

N. Stress and Social Situation

Please answer the following questions from your own perspective, not necessarily your partner's.

(N-01) With reference to you or your partner's fertility problems and treatment, do you feel that:
[Please mark ☒ one answer for each line]

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My life has changed very much	☐	☐	☐	☐	☐
My life has been disrupted as a result	☐	☐	☐	☐	☐
It is stressful for me to deal with	☐	☐	☐	☐	☐

(N-02) How have you or your partner's fertility problems affected your marriage/partnership?
[Please mark ☒ one answer for each line]

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Brought us closer together	☐	☐	☐	☐	☐
Strengthened our relationship	☐	☐	☐	☐	☐
Caused crisis in our relationship	☐	☐	☐	☐	☐
Caused thoughts of divorce	☐	☐	☐	☐	☐

(N-03) How much stress has you or your partner's fertility problems placed on the following? [Please mark ☒ one answer for each line]

	A lot	Some	A little	None
Your marriage/partnership	☐	☐	☐	☐
Your sex life	☐	☐	☐	☐
Your relationships with your family	☐	☐	☐	☐
Your relationships with your family-in-law	☐	☐	☐	☐
Your relationships with friends	☐	☐	☐	☐
Your relationships with workmates	☐	☐	☐	☐
Your relationships to people with children	☐	☐	☐	☐
Your relationships to pregnant women	☐	☐	☐	☐
Your physical health	☐	☐	☐	☐
Your mental health	☐	☐	☐	☐
Your financial condition	☐	☐	☐	☐

(N-04) Do you get support and understanding from any of the following people in relation to you or your partner's fertility problems or treatment? [Please mark ☒ one answer for each line]

	Always	Often	Sometimes	Rarely	Never	Don't have
Family	☐	☐	☐	☐	☐	☐
Partner	☐	☐	☐	☐	☐	☐
Partner's Family	☐	☐	☐	☐	☐	☐
Friends	☐	☐	☐	☐	☐	☐
Colleagues	☐	☐	☐	☐	☐	☐
Others	☐	☐	☐	☐	☐	☐

Who? _____

(N-05) Do you experience that some people react negatively to you or your partner's fertility problems or treatment? [Please mark ☒ one answer for each line]

	Always	Often	Sometimes	Rarely	Never	Don't have
Family	☐	☐	☐	☐	☐	☐
Partner	☐	☐	☐	☐	☐	☐
Partner's Family	☐	☐	☐	☐	☐	☐
Friends	☐	☐	☐	☐	☐	☐
Colleagues	☐	☐	☐	☐	☐	☐
Others	☐	☐	☐	☐	☐	☐

Who? _____

P. Demographic Information

(P-01) How many years of schooling have you had? (Please mark ☒ one)

☐ 8 or less ☐ 9-10 ☐ 11-12 ☐ 13-15 ☐ 16-18 ☐ more than 18

(P-02) What is your race? (Please mark ☒ all that apply)

☐ Aborigine ☐ Alaskan Native ☐ American Indian/Native American ☐ Asian
☐ Black ☐ Hawaiian Native ☐ Hispanic/Latino ☐ Pacific Islander ☐ White
☐ Other, please specify: _____

(P-03) What is your religious preference? (Please mark ☒ one)

☐ Catholic ☐ Islamic ☐ Jewish ☐ Latter-day Saint ☐ Orthodox Christian
☐ Protestant ☐ None ☐ Other, please specify: _____

(P-04) About how often do you usually attend religious or worship services? (Please mark ☒ one)

☐ More than once per week ☐ Weekly ☐ Monthly ☐ Less than monthly ☐ Never

(P-05) What is your current occupation? (Please mark ☒ one)

☐ Professional ☐ Technical ☐ Clerical/Sales ☐ Skilled laborer ☐ Unskilled laborer
☐ Homemaker ☐ Student ☐ Educator
☐ Other, please specify: _____

Q. Additional Comments or Questions

Please write any additional comments or questions you have about the issues addressed by this questionnaire:

_____

_____

_____

_____