**MAN’S INITIAL QUESTIONNAIRE**  
Natural Procreative Technology Evaluation for Infertility or Miscarriage

**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Introduction and Purpose of this Questionnaire</td>
</tr>
<tr>
<td>3</td>
<td>A. Initial Information</td>
</tr>
<tr>
<td>4</td>
<td>B. Trying to Have a Baby</td>
</tr>
<tr>
<td>4</td>
<td>C. Andrologic History (Male Sexual Health)</td>
</tr>
<tr>
<td>5</td>
<td>D. Family Planning History</td>
</tr>
<tr>
<td>5</td>
<td>E. Previous Fertility-Related Investigations</td>
</tr>
<tr>
<td>6</td>
<td>F. Previous Fertility-Related Diagnoses</td>
</tr>
<tr>
<td>7</td>
<td>G. Previous Fertility-Related Surgeries</td>
</tr>
<tr>
<td>7</td>
<td>H. Previous Fertility-Related Medical Treatments</td>
</tr>
<tr>
<td>7</td>
<td>I. Experience of Past Fertility Treatment</td>
</tr>
<tr>
<td>9</td>
<td>J. Adoption</td>
</tr>
<tr>
<td>9</td>
<td>K. General Health History</td>
</tr>
<tr>
<td>12</td>
<td>L. Family History</td>
</tr>
<tr>
<td>13</td>
<td>M. Health Habits</td>
</tr>
<tr>
<td>14</td>
<td>N. Stress and Social Situation</td>
</tr>
<tr>
<td>15</td>
<td>P.* Demographic Information</td>
</tr>
<tr>
<td>15</td>
<td>Q. Additional Comments or Questions</td>
</tr>
</tbody>
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(* To avoid confusion with zero, there is no section O.)
Introduction and Purpose of the Man's Initial Questionnaire

Why you are receiving this questionnaire
You are being given this Man's Questionnaire because you or your partner have scheduled an initial evaluation for infertility or miscarriage. This questionnaire comprehensively addresses relevant issues for your evaluation and treatment. It was designed by physicians working with Natural Procreative Technology.

How this questionnaire will be used
Your physician will use the information from this questionnaire and the separate questionnaire from your partner to provide important information for the medical evaluation and your desires for treatment. We will discuss your responses to many of the items in this questionnaire during our initial visit, and subsequent visits, as needed.

Natural Procreative Technology (NPT, NaProTechnology)
Our approach to evaluating and treating fertility or pregnancy problems is based on Natural Procreative Technology (NPT, NaProTechnology). During our visits, we will explain to you specific recommendations for your unique situation. General information about NPT is available at www.reproductiveinstitute.com.

What to bring to the first (or next) visit
Please bring this questionnaire, even if you haven’t finished filling it out. Please also bring copies of medical records from any previous evaluations or treatments for infertility that you or your partner may have had. In some cases, it may be more convenient for you to mail these items. It is best if both you and your partner can attend the initial consultation.

Why there are two questionnaires: woman’s and man’s
Our experience has shown that women and men remember and perceive things differently with regard to a couple’s fertility problems. In addition, some information is specific to the woman or the man.

Sensitive questions
You may skip any question you are uncomfortable answering. If you choose to skip a question, please place a line through the question rather than leaving it blank. There may be items that you would prefer not to discuss in front of your partner. If so, you may CIRCLE the question number to tell us that your response to this question is confidential and that you prefer that this item NOT be discussed with your partner.

Estimated time to complete questionnaire
It is estimated that this questionnaire will take about 30 minutes to complete for most men.

Questions or comments
If you have any questions or comments or feel a question is inappropriate for your situation, please make a mark or write a comment at the question or at the end of questionnaire. You may also discuss any questions or comments with your health provider.

Where to return the questionnaire
Please return the questionnaire to your health provider at the time of your or your partner’s next appointment. Alternatively, you may mail it to your provider.

Option to participate in the iNEST study
Your health care provider may invite you to participate in an ongoing clinical study to assess live birth rates among those who consider or receive NPT treatment to conceive or maintain pregnancy. This study is known as the international NaProTechnology Evaluation and Surveillance of Treatment (iNEST). The purpose of the iNEST study is to understand the use of NPT, and characteristics that may help us predict how successful NPT can be for each couple for infertility or miscarriage.

Whether or not you participate in the iNEST study will not affect the clinical care that you receive. When you are asked, you may choose whether or not to participate in the iNEST study. If you participate,
your answers from this questionnaire will be recorded confidentially for the study. If you do not participate, your answers from this questionnaire will not be reported to the study.
A. Initial Information

(A-01) Today’s Date [___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___] (example: 17 / Mar / 2005)

Day / Month / Year

(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

→ If not married, please skip to question A-06 below; if yes, continue to question A-04.

(A-04) In what month and year did you marry? [___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___]

Month / Year

(example: Mar / 1985)

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

(A-06) How did you learn about Natural Procreative Technology (NPT, NaPro)? (Please mark ☐ all that apply)
☐ Physician or other health professional
☐ On the web
☐ Written flyer or brochure
☐ A friend or acquaintance who had NPT treatment
☐ Public presentation
☐ Church
☐ Newspaper or magazine article
☐ Other, please describe: _____________________________________________________________

(A-07) Why have you decided to try NPT?

____________________________________________________________________________________

____________________________________________________________________________________

Please continue on the next page.
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-01) Using this definition, in what month and year did you start trying to have a baby with your partner?  

\[\text{Month} / \text{Year}\]  \(\text{example: Mar / 1985}\)

(B-02) During the time you have been trying to have a baby, was there any time when you or your partner did something to avoid pregnancy (such as abstinence during fertile days, condoms, withdrawal, or other contraception of any kind) for more than one month?  

☐ Yes  ☐ No  

If yes, for how many months total? ________________

(B-03) During the time you have been trying to have a baby, was there any time when you and your partner did not have intercourse for more than one month?  

☐ Yes  ☐ No  

If yes, for how many months total? ________________

(B-04) During the time you have been trying to have a baby, how often do you and your partner have intercourse, in general?  

_____ Times per month  OR  _____ Times per week

(B-05) How often do you use lubricants when you have intercourse?  (Please mark  one)  

Always  Often  Sometimes  Rarely  Never  

☐  ☐  ☐  ☐  ☐

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

(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-01) Have you ever used natural family planning (NFP)?
☐ Yes ☐ No
If yes:
Which NFP method(s)? ________________________________________________________________
Over your lifetime, how long did you use or have you used NFP? ______Year(s) ______Month(s)
What is the date of your last use of NFP?  [___] [___] [___] / [___] [___] [___] (example: Mar / 1985)

(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)

(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)

(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
→If no, please skip to question E-03 on next page; if yes, continue to question E-02.

(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-03) Have you and your partner had a post-coital test (a test for sperm in woman’s cervix after intercourse)?

☐ Yes   ☐ No   ☐ Unsure

If yes, in what month and year was the most recent test?

[ ] [ ] [ ] / [ ] [ ] [ ] [ ]  (example: Mar / 1985)

Month / Year

What was the result of the most recent test?

☐ Normal ☐ Abnormal ☐ 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.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Surgery</th>
<th>Date of Surgery</th>
<th>Date of Surgery</th>
<th>Date of Surgery</th>
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<tr>
<td></td>
<td></td>
<td>Circumcision</td>
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<td></td>
<td></td>
<td>Vasectomy</td>
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<td>Vasectomy Reversal</td>
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<td>Removal or ligation of varicocele</td>
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<td>Surgery on the Prostate</td>
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<td>Surgery on the Penis</td>
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<td>Surgery on the Testis</td>
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<td></td>
<td></td>
<td>Surgery on the Epididymis</td>
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</table>

(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-01) In order to achieve pregnancy, have you and your partner ever used artificial insemination?

☐ Yes    ☐ No

If yes:

How many cycles with your sperm? ______________

How many cycles with donor sperm? ______________

(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, page 9; 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)

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<th>Bad</th>
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<th>3</th>
<th>4</th>
<th>Excellent</th>
<th>5</th>
<th>Don’t know/not relevant</th>
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(I-03) Did they involve you in decisions? (Please mark ⌂ one)

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

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

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

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

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<th>Don't know/not relevant</th>
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(I-08) Did they deal with emotional consequences of your infertility or miscarriage and treatment? (Please mark ⌂ one)

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<th>3</th>
<th>4</th>
<th>5</th>
<th>Don't know/not relevant</th>
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<td>Bad</td>
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<td>Excellent</td>
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(I-09) Did they make a treatment plan adjusted to your special situation? (Please mark ⌂ one)

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<th>4</th>
<th>5</th>
<th>Don't know/not relevant</th>
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<tr>
<td>Excellent</td>
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(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)

<table>
<thead>
<tr>
<th></th>
<th>Not at all satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Excellent</td>
<td>10</td>
<td>1</td>
</tr>
</tbody>
</table>

Please turn over the page to continue.
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  ☐ Allergic skin reaction
☐ Varicose veins  ☐ Allergies such as hay fever  ☐ Rheumatoid arthritis  ☐ Blood clots
☐ Seizures  ☐ Thyroid disease  ☐ Heart disease  ☐ Chronic fatigue syndrome
☐ High blood pressure  ☐ Kidney disease  ☐ Liver disease  ☐ Crohn’s disease
☐ Kidney disease  ☐ Fibromyalgia  ☐ Multiple sclerosis  ☐ Sjogren’s syndrome
☐ Ulcerative colitis  ☐ Scleroderma  ☐ Frequent diarrhea  ☐ Frequent constipation
☐ Scleroderma  ☐ Non-insulin-dependent diabetes mellitus  ☐ Insulin-dependent diabetes mellitus
☐ Other autoimmune disease (describe): ________________________________________________________
☐ Hormone problems (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:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Please continue on the next page.
(K-04) What has been your lowest weight as an adult?
        ______Pounds
        or ______Kilograms
        or ______Stones and ______Pounds

(K-05) What has been your highest weight as an adult?
        ______Pounds
        or ______Kilograms
        or ______Stones and ______Pounds

(K-06) What is your current weight?
        ______Pounds
        or ______Kilograms
        or ______Stones and ______Pounds

(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
        □ 1  □ 2  □ 3  □ 4  □ 5  □ 6  □ 7  □ 8  □ 9  □ 10

(K-13)  Sleep Disturbance
        Minimal
        □ 1  □ 2  □ 3  □ 4  □ 5  □ 6  □ 7  □ 8  □ 9  □ 10

(K-14)  Low Mood or Feeling Depressed
        Minimal
        □ 1  □ 2  □ 3  □ 4  □ 5  □ 6  □ 7  □ 8  □ 9  □ 10

(K-15)  Anxiety
        Minimal
        □ 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) Do 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 below; 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?

<table>
<thead>
<tr>
<th></th>
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<th>/</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

(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, continue to question M-06.

(M-06) Do you currently use tobacco in some form?
☐ Yes  ☐ No

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

<table>
<thead>
<tr>
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<th>/</th>
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<th></th>
<th></th>
</tr>
</thead>
</table>

(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? (1 unit = glass (half-pint) of beer, 1 measure of spirits, 1 small glass of wine) (Please mark one)

☐ 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]

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My life has changed very much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My life has been disrupted as a result</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>It is stressful for me to deal with</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brought us closer together</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthened our relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caused crisis in our relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caused thoughts of divorce</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>A lot</th>
<th>Some</th>
<th>A little</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your marriage/partnership</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Your sex life</td>
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<td></td>
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<tr>
<td>Your relationships with your family</td>
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<td></td>
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<tr>
<td>Your relationships with your family-in-law</td>
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<td></td>
<td></td>
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<tr>
<td>Your relationships with friends</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Your relationships with workmates</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Your relationships with people with children</td>
<td></td>
<td></td>
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<tr>
<td>Your relationships with pregnant women</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Your physical health</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Your mental health</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Your financial condition</td>
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</tbody>
</table>

(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]

<table>
<thead>
<tr>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don’t have</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner’s Family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colleagues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
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</tr>
</tbody>
</table>

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]

<table>
<thead>
<tr>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don’t have</th>
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<tr>
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<tr>
<td>Others</td>
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</tbody>
</table>

Who? _______________________________________________________________

Please turn over the page to continue.
**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: _______________________________

(P-06) What is your approximate yearly total household income? (Please mark one)
- [ ] Under $12,000
- [ ] $12,001-25,000
- [ ] $25,001-50,000
- [ ] $50,001-75,000
- [ ] $75,001-100,000
- [ ] Over $100,000

**Q. Additional Comments or Questions**

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

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please continue on the next page.