Andrology testing questionnaire

|  |  |
| --- | --- |
| Surname |  |
| Forename |  |
| Date of Birth |  |
| When was the semen sample produced? | Date / /  Time |
| Was the whole sample collected?  (Please circle) | YES / NO |
| When was the last time you had any sexual activity that resulted in an ejaculation? | Date / /  Time |

I (patient/patient representative) confirm that the information provided on this form is correct

Signature (patient/patient representative)………………………………………………

Full name (if patient representative)…………………………………………................

|  |
| --- |
| FOR LAB USE ONLY  Time/date received:  Patient information checked by: |