Andrology testing questionnaire

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| --- | --- |
| 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)…………………………………………................

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| FOR LAB USE ONLYTime/date received:Patient information checked by: |