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PATIENT VASECTOMY QUESTIONNAIRE

Patient Name: _____

Date: _____

Referred by: _____

Describe the health problem for which you are seeking care today:
(Chief Complaint)

_____

_____

Your age: years old

This section for doctor use only

_____

VASECTOMY HISTORY (Begin Here)

Have you had an infection in the testicle area? Yes No

Have you ever been injured in the scrotal area Yes No

If so, please describe_____

_____

Have you ever had an inguinal hernia repair Yes No

Have you had prostatitis (inflamation of the prostate) before? Yes No

If yes, what medication were you treated with and for how long?

_____

_____

Is there anyone in your family who has had Prostate cancer? Yes No
If so, which relative was/is he? _____

Are you having sexual problems? Yes No

Have you had any conditions affecting the urine, kidneys, bladder, prostates, testicles or penis?

_____

_____

Did you look on the Internet for information on vasectomies? Y or N

What main Internet search engine do you use?

_____

After reading the information that was sent to you by the office about vasectomy, what, if any, additional questions do you have?

_____
_____
_____

Please mark here ☐ if you have not had an opportunity to read the vasectomy information before your visit.

Your Past Medical & Surgical History:

Illnesses – please circle all that apply and list others:

High blood pressure	Diabetes	Bleeding problems	Kidney problems
Heart disease	Arthritis	Liver disease/hepatitis	Stomach ulcers/reflux
Heart arrhythmia	Osteoporosis	Glaucoma	Thyroid problem
Cancer type_____	Stroke	Heart murmur	Venereal diseases

Other_____

Other hospitalizations_____

Do you use antibiotics for prevention for dental or medical procedures? No Yes _____

Operations – list any operations you have had and the year of the procedure

_____
_____
_____
_____

Fractures & Injuries – list any fractures or serious accidents you have had:

_____

Medications – list all prescription and non-prescription medications you use with the **doses**:
(include aspirin, hormones, birth control pills, laxatives, vitamins, calcium and others)

_____
_____
_____
_____
_____

ALLERGIES (include medication, iodine, seafood, latex & others) **REACTION**

_____ _____
_____ _____
_____ _____
_____ _____

Your Family's Medical History – list illnesses of your blood relatives (include heart disease, diabetes, cancer, high blood pressure, kidney disease, gout, osteoporosis, bleeding problems)

Living relations	**Illness**	**Deceased relations**	**Illness/Cause of death**
_____		_____	
_____		_____	

Patient Name:

Social History – please circle or fill in the blank

Tobacco use: Never Presently Past (year quit _____) ____ packs a day for ____ years
Alcohol use: None Occasional Regular _____
Your occupation: _____ Are you retired? Yes No

Marital status: Single Married Divorced Widowed Religious reference (optional)_____
Your partner's name: _____ Partner's occupation_____
How long have you been married to your present wife? ____ years
Is the marriage stable? Y or N

Children by this marriage?

Name Ages Sex Health

_____
_____
_____

Children from previous marriage:_____ Ages:_____

How many children are living with you: _____

Complete Review of Systems

Circle any current or recent problems with the following:

CONSTITUTIONAL
- Any recent weight change Y N
- Fever or chills Y N
- Headache Y N

CARDIOVASCULAR
- Chest pain or angina Y N
- Swelling of legs Y N
- Varicose veins Y N
- Other _____

HEMATOLOGIC/LYMPHATIC
- Easy bruising or bleeding Y N
- Anemia Y N
- Swollen glands Y N
- Other _____

MUSCULOSKELETAL
- Joint pain Y N
- Back pain Y N
- Neck pain Y N
- Other _____

NEUROLOGIC
- Numbness/tingling Y N
- Tremors Y N
- Seizures Y N
- Dizziness Y N
- Other _____

INTEGUMENTARY(SKIN)
- Skin rash Y N
- Itching Y N
- Other _____

RESPIRATORY
- Cough Y N
- Wheezing Y N
- Shortness of breath Y N
- Other _____

GASTROINTESTINAL
- Abdominal pain Y N
- Nausea or vomiting Y N
- Blood in stool Y N
- Black stool Y N
- Recent change in stool Y N
- Heartburn/indigestion Y N
- Hemorrhoids Y N
- Other _____

GENITOURINARY
- Leaking urine Y N
- Frequent urinary infections Y N
- Urinary retention Y N
- Other _____