Norman Urology Associates P.C
S. Edward Dakil, M.D. Philip L. Jones, M.D. Clifton L. Whitesell, M.D.
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PRE-VASECTOMY INSTRUCTIONS

On the day of your vasectomy, you should shower and wear something comfortable and loose. Bring scrotal support, such as an athletic supporter or tight briefs to put on after the procedure. If you are taking blood thinners or aspirin please discontinue three days prior to procedure.

POST-VASECTOMY INSTRUCTIONS

You will be given two prescriptions. One is an antibiotic, and you must take all of this medicine. The other is for pain, and it is to be taken as needed.

You will be given a specimen container. Please bring a semen specimen in four weeks or after 10-15 ejaculations for the doctor to check. This is important and an appointment is not necessary. Until then, stay on your present form of birth control. Very rarely, the severed ends of the vas may grow back together. To ensure that this has not happened, you must bring another semen sample back in four months.

You may find an ice pack to be helpful in relieving discomfort. Gradually advance your physical activity over the next two weeks as tolerated. A small amount of swelling and bruising is to be expected, however, please feel free to call our office if you have any questions or concerns.

DEPOSIT

There is a $50.00 deposit required for all vasectomy procedures one week prior to appointment. The appointment will be cancelled without further notice if the deposit is not received. This can be done over the phone by credit card or check by mail. After the deposit is received, a 48-hour advance notice is required in order to receive a refund if you must cancel the vasectomy.

DATE _____

NORMAN UROLOGY ASSOCIATES, P.C.

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PLEASE PRINT

The following information is needed to provide the best possible urological care and treatment for you and will be held in strict confidence. It will not be released without your authorization.

NAME _____
(Last) (First) (Middle)
DATE OF BIRTH_____ **AGE** _____ **MARITAL STATUS** _____

Primary Care Physician _____**Number of Children** _____

What is the reason for your visit today?

_____

_____

Do you have pain or discomfort today? _____Where? _____

UROLOGICAL HISTORY:

Approximately how often do you urinate in the daytime? _____

Approximately how many times do you get up from sleep to urinate? _____

Is urinating uncomfortable? _____ Urgent? _____ Are you ever incontinent of urine (leak urine) ? _____

If so, how often? (every day, occasionally or rarely) _____

Have you ever had blood in urine? no yes Explain _____

How many bladder or kidney infections have you had in your lifetime? _____

Have you ever had or passed a kidney stone? no yes How many? _____ When? _____

Have you ever had prostate problems? no yes Explain _____

Have you ever had any of the following:

Bladder cancer no yes Testicular cancer no yes

Kidney cancer no yes Penile cancer no yes

Prostate cancer no yes Explain _____

_____

Are you currently sexually active? no yes

Are you having any sexual difficulty that you would like to discuss with the Doctor? no yes

PAST MEDICAL HISTORY:

Have you ever had the following:

			Explain
AIDS or HIV positive	no	yes	_____
Cancer	no	yes	_____
Bleeding tendency	no	yes	_____
Malignant Hyperthermia	no	yes	_____
Glaucoma	no	yes	_____
Diabetes	no	yes	_____
High or low blood pressure	no	yes	_____
Thyroid disease	no	yes	_____
Back trouble	no	yes	_____
Asthma	no	yes	_____
COPD, Emphysema	no	yes	_____
Pneumonia	no	yes	_____
Heart disease	no	yes	_____
Stroke	no	yes	_____
Mitral valve prolapse	no	yes	_____
Heart Murmur	no	yes	_____
Hernia	no	yes	_____
Kidney disease	no	yes	_____
Venereal disease	no	yes	_____
Sexually transmitted disease	no	yes	_____
Migraine headaches	no	yes	_____
Depression	no	yes	_____
Emotional disorder	no	yes	_____
Arthritis	no	yes	_____
Hepatitis	no	yes	_____

Please list all previous surgeries and what year they occurred:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you been hospitalized in the last year? no yes Explain _____

_____

_____

HABITS:

Do you smoke? no yes Number of packages per day: _____

Have you ever smoked? no yes Total number of years you smoked: _____

I quit _____ years ago.

Do you drink any of the following beverages? If so, how much per week?

Coffee _____ Tea _____ Beer _____

Liquor _____ Pop _____

ALLERGIES:

Are you allergic to any medications or solutions? (Example: antibiotics, iodine, x-ray dye) Please list:

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICATIONS:

Please list current medications and dosage: (Example: birth control pills, hormones, insulin)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY: Has any member of your immediate family had any of the following:

			Relationship
Prostate cancer	no	yes	_____
Kidney cancer	no	yes	_____
Cancer (other)	no	yes	_____
Kidney disease	no	yes	_____
Kidney stone disease	no	yes	_____
Diabetes	no	yes	_____
Heart disease	no	yes	_____
High blood pressure	no	yes	_____
Stroke	no	yes	_____
Bleeding tendency	no	yes	_____
Malignant Hyperthermia	no	yes	_____

REVIEW OF SYSTEMS:

Do you have now or have you had within the past month any of the following:

CONSTITUTIONAL SYMPTOMS:

Weight loss	no	yes
Weight gain	no	yes
Fatigue	no	yes
Night sweats	no	yes
Hot flashes	no	yes
Persistent fever	no	yes

EYES:

Double vision	no	yes
Blurred vision	no	yes

NEUROLOGIC:

Weakness or paralysis	no	yes
Dizziness or fainting spells	no	yes
Memory loss	no	yes
Seizures	no	yes
Poor coordination	no	yes

ALLERGIC/IMMUNOLOGIC:

Allergic to pollen, mold or dust	no	yes

CARDIOVASCULAR:

Tire easily or weak	no	yes
Swelling of hands, feet or ankles	no	yes
Chest pain or discomfort	no	yes
Palpitations or fluttering heart	no	yes

MUSCULOSKELETAL:

Joint pain or stiffness	no	yes
Muscle cramps or spasms	no	yes
Backaches	no	yes
Swollen joints	no	yes

EAR/NOSE/THROAT/MOUTH:

Hearing loss	no	yes
Changes in voice	no	yes
Hoarseness	no	yes
Difficulty swallowing	no	yes

INTEGUMENTARY:

Skin rash	no	yes
Skin trouble or changes	no	yes
Changes in nails or hair	no	yes

GASTROINTESTINAL:

Recent weight change	no	yes
Change in appetite	no	yes
Difficulty swallowing	no	yes
Heartburn	no	yes
Abdominal cramping	no	yes
Nausea	no	yes
Vomiting	no	yes
Rectal Bleeding	no	yes
Hemorrhoids	no	yes

RESPIRATORY:

Shortness of breath	no	yes
Bloody sputum	no	yes
Wheezing	no	yes