

THE VASECTOMY CLINIC™

Patient Questionnaire

Please answer each of the questions on this page. It is important that we have an accurate knowledge of your background, medical history, reproductive history, and future plans and expectations in order to best serve you.

1. Your name _____ 6. Wife/partner's name _____
 2. Your age: _____ 3. Education/grade: _____ 7. Her age: _____ 8. Education/grade: _____
 4. Your occupation _____ 9. Her occupation _____
 5. Your marriage: 1st 2nd 3rd other _____ 10. Her marriage: 1st 2nd 3rd other _____

11. Years in this relationship: _____ 12. Do you consider this relationship permanent? Yes No

13. Children:

	1	2	3	4	5	6
Age:						
Sex: Male / Female	M F	M F	M F	M F	M F	M F
Ours / Mine / Hers / Adopted						
Living with me: Yes / No	Y N	Y N	Y N	Y N	Y N	Y N

14. Do you wish to have more children in the future? YES ___ NO ___ UNCERTAIN ___
 15. Would you consider adoption if you chose to have more children? YES ___ NO ___
 16. For how long have you considered vasectomy? _____
 17. Have you considered tubal ligation as an alternative sterilization choice? YES ___ NO ___
 18. Have you considered temporary birth control methods (condoms, diaphragm)? YES ___ NO ___
 19. Circle your current method of birth control. Underline others you have used:
 Abstinence NONE Condoms Diaphragm IUD Pill Patch Shot Other _____
 20. Does vasectomy conflict with your religion? YES ___ NO ___
 21. Do you have or does your partner have any sexual problems or concerns? YES ___ NO ___
 22. Are you choosing vasectomy because of a genetic disease? YES ___ NO ___
 because of your health? YES ___ NO ___ your wife's health? YES ___ NO ___
 23. What do you consider to be your current state of health? GOOD ___ FAIR ___ POOR ___
 24. Have you had care for mental illness or depression? YES ___ NO ___
 25. Do you think you are more sensitive to pain than the average person? YES ___ NO ___
 26. Are you prone to fainting? YES ___ NO ___
 27. Do you or anyone in your family have a bleeding tendency or disorder? YES ___ NO ___
 28. Have you had a kidney disorder or abnormal kidney function? YES ___ NO ___
 29. Have you had prostatitis, epididymitis, gonorrhea, chlamydia, hepatitis, AIDS? YES ___ NO ___
 30. Have you ever had a hernia, infection, tumor, or abnormality of the scrotum or testes? YES ___ NO ___
 31. Have you ever had a serious injury or surgery to the testicles or scrotal area? YES ___ NO ___
 32. List all surgeries you have had: _____
 33. Did you have any complications or excessive pain or bleeding after surgery? YES ___ NO ___
 34. Name all medicines you have taken in the last two weeks: _____
 35. Have you used any aspirin products within the last 5 days? YES ___ NO ___
 36. List any allergy to a drug, medication, or anesthetic: _____
 37. List all major illnesses you have had: _____