Austin Fertility & Reproductive Medicine
Westlake IVF

Vasectomy Questionnaire

Name: _____ Age: _____

Who referred you/how did you hear about us?
Dr. _____ or
Internet _____ or
Friend/Family _____ or

How many children do you have?

Past Medical History:
What medical problems do you have? (ex: high blood pressure, diabetes, etc)

Past Surgical History:
List all of the surgeries that you have ever had.

Medications:
List any medications including prescription, over the counter, herbs, and supplements that you take (with doses if you know them).

Allergies:
List any medications that you are allergic to and what kind of reaction you had to them.

Social History:
Are you married? Yes / No

Spouse/Partner's full name: _____

Do you smoke? Yes / No
If so how many cigarettes per day and how many years have you been smoking? _____

Do you drink alcohol? Yes / No
If so how many drinks do you have? _____

Do you use any illicit drugs? Yes / No

If so, what kind and how often? _____

What is your occupation? _____

Family History:

Do any medical problems (such as cancer) run in the family? Yes / No

If yes, what are they?

Review of Systems:

General:
Have you had any fevers, change in weight, or weakness?

Dermatologic:
Have you had any change in skin, hair or nails?

Pulmonary:
Have you had any cough, wheezing, or difficulty breathing?

Endocrine:
Have you had any heat or cold intolerance or any excess hair growth?

Cardiovascular:
Have you had any chest pain, feeling of your heart skipping beats, or swelling in your legs?

Neurologic:
Have you had any seizures, tremors, or numbness?

Psychologic:
Have you had any depression, anxiety, or lack of interest in doing things that you used to enjoy?

Hematologic:
Do you bruise or bleed easily? Have you been diagnosed with anemia?

Gastrointestinal:
Do you have nausea, diarrhea, or constipation?

Genitourinary:
Do you have blood that you can see in your urine, difficulty urinating, or burning when you urinate?

Patient's signature_____ Date _____