PATIENT REGISTRATION

THE VASECTOMY DOCTOR

YOUR INFORMATION				
Name			Occupation	
Date of Birth			Age	
Address				
Contact Numbers	Home			
	Work			
	Mobile			

PARTNER INFORMATION (Please skip to family situation if you have no partner)		
Age of Partner		
Is your partner aware of your vasectomy?	Y / N	

FAMILY SITUATION			
Number of Children	That you have		Current Birth Control Methods
	That your partner has		
	Living at home		
	Age of Youngest Child		

MEDICAL HISTORY (Have you had/do you have any of the following)		
Known testicle or scrotal conditions	Y / N	If yes, please elaborate
Previous testicle or scrotal surgery	Y / N	
Sexually transmitted infection/s	Y / N	
Hernia repair	Y / N	
Problems with bleeding or clotting	Y / N	
Anxiety around procedures	Y / N	

MEDICATIONS		
Are you on blood thinning medication?	Y / N	
Please list any Medications you are currently taking		Please list any allergies/reactions
Do you smoke? (and how much)	Y / N (please circle) …… cigarettes/day	
Do you drink alcohol?	Y / N (please circle) …… standard drinks/day	