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VASECTOMY REGISTRATION FORM

PATIENT INFORMATION **Date: _____**

_____ _____
LAST NAME FIRST NAME

_____ _____
DATE OF BIRTH M/D/Y OHIP NUMBER

_____ _____ _____
ADDRESS CITY POSTAL CODE

_____ _____ _____
HOME PHONE PREF. CONTACT *(if diff)* EMAIL

_____ _____ _____
EMERGENCY CONTACT NAME PHONE

FAMILY INFORMATION

What is your current relationship status?
☐ Single ☐ Common Law ☐ Married ☐ Divorced ☐ Separated

Length of relationship:_____ Partner's Age:_____

Do you have children together? ☐ No ☐ Yes Age(s):_____
Do you have children from a previous relationship? ☐ No ☐ Yes Age(s):_____
Is your partner currently pregnant? ☐ No ☐ Yes Delivery date:_____

CONTRACEPTION

☐ Birth control pill ☐ Cervical cap ☐ Condom ☐ Depoprovera
☐ Diaphragm ☐ IUD ☐ Rhythm ☐ Tubal Ligaton
☐ Withdrawal ☐ Other (please specify):_____

MEDICAL HISTORY

Please check any of the following that apply to you: (Please tick all that applies)

Ache, pressure or pain in the testicle or groin…… ☐

Bleeding problems (including family history of it)…….. ☐

Depression …….. ☐

Epilepsy…….. ☐

Hepatitis A, B, C…… ☐

Prostatitis…… ☐

Diabetes…….. ☐

AIDS…… ☐

Other…… ☐

Genital warts…… ☐

Herpes…… ☐

Scrotal or testicular injury or trauma…… ☐

Undescended testis…….. ☐

History of fainting due to medical procedure or injection…… ☐

Are you bothered by a tight band on the underside of your penis causing pain or bleeding during sex?…… ☐

Have you ever considered having a circumcision for any medical or personal reasons?..... ☐

SURGICAL HISTORY

Please check if you have had any of the following:

Hernia…….. ☐

Previous vasectomy…….. ☐

Vasectomy reversal…… ☐

Scrotal or testicular surgery …… ☐
(including lowering of undescended testis)

MEDICATIONS

Please list any medications you are taking including name and dosage: (including Aspirin, Advil, other anti-inflammatories)

_____

ALLERGIES

_____