**Name:** _____
Address: _____
_____
May we send mail to this address?
Circle: Yes No

| | |
|---|---|
| Vasectomy site: | **The Surgery, Wellingtonbridge, Co. Wexford** |
| Vasectomy date: | |
| Age: | |
| Date of Birth: | |

Phones: Home: (_____) _____--_____
Mobile: (_____) _____--_____
Work: (_____) _____--_____

Preferred phone: Circle: Home Mobile Work

E-mail address: _____

Employer: _____
Occupation: _____

Exertion (circle): Heavy Moderate Light

Marital status: _____
Wife's / girlfriend's name: _____
Wife / girlfriend aware: Circle: YES NO
OK to communicate w partner? Circle: YES NO
Wife's / girlfriend's age: _____
Years with partner: _____
Children with partner: _____
Total children: _____
Partner's total children: _____
Age of youngest child: _____
Pregnancies all planned? Circle: YES NO
Partner pregnant now? Circle: YES NO

Birth control method past few mos.: _____

**Primary Care Physician**

PCP: Name: _____
Address: _____
_____
_____

Permission to contact: Circle: YES NO

**Allergic to any medications?** Circle: YES NO
Allergic to: _____, _____, _____
Taking any **prescribed medications?** Circle: YES NO
Meds: _____ For _____
_____ For _____
_____ For _____

**Partner's OB/GYN**

GYN: Name: _____
_____
Address: _____
_____
_____

Permission to contact: Circle: YES NO

Primary referral source: _____

Other referral sources:
_____
_____
_____

Have you had any of the **following**? Circle: YES NO
If yes, **circle** the underlined words:

- Hernia surgery as an infant or child
- Hernia surgery as an adult
- Surgery as a child for undescended testicle
- Surgery for a torsion or twisted testicle
- Removal of a testicle
- Prior vasectomy or prior vasectomy and reversal
- Any other type of scrotal or testis surgery

Have you had any **other operations**? Circle: YES NO
Other surgery: _____, _____, _____

Have you had any of these **problems**? Circle: YES NO
If yes, **circle** the underlined words:

- Bleeding or easy bruising
- Difficulty getting or maintaining erections
- Difficulty reaching a climax
- Premature ejaculation
- Tendency to get lightheaded or faint
- Herpes
- Genital warts
- Epididymitis
- Varicocele
- HIV

The information above is correct. I authorize release of any medical information necessary that an insurance company may request to process a claim if I seek reimbursement. I request payment of insurance benefits to myself. I understand and accept that I am responsible for any and all charges incurred for professional services rendered to me. I also understand and accept that I am responsible for any charges incurred should collection proceedings become necessary to enforce this agreement.

Signed: _____ Date: _____