

Name: _____ Mailing Address: _____ _____, FL _____	Vasectomy site:	_____
	Vasectomy date:	_____
	Age:	_____
	Date of Birth:	_____

Phones: Home: (____) ____--____ Cell: (____) ____--____ Preferred phone: Circle: Home Cell E-mail address: _____	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.: _____
Employer: _____ Occupation: _____ Exertion (circle): Heavy Moderate Light	

Primary Care Physician PCP: Name: _____ Address: _____ _____, FL, _____ 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 _____
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Partner's OB/GYN GYN: Name: _____ Address: _____ _____, FL, _____ Permission to contact: Circle: YES NO	Have you had any of the following ? Circle: YES NO If yes, circle the underlined words: <ul style="list-style-type: none"> ▪ Hernia surgery as an <u>infant</u> or child ▪ Hernia surgery as an <u>adult</u> ▪ Surgery as a child for <u>undescended</u> testicle ▪ Surgery for a <u>torsion</u> or twisted testicle ▪ <u>Removal</u> of a testicle ▪ <u>Prior</u> vasectomy or prior vasectomy and reversal ▪ Any <u>other</u> type of scrotal or testis surgery
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Primary referral source: _____	Have you had any other operations ? Circle: YES NO Other surgery: _____, _____, _____
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Other referral sources: _____ _____ _____	Have you had any of these problems ? Circle: YES NO If yes, circle the underlined words: <ul style="list-style-type: none"> • <u>Bleeding</u> or easy bruising • <u>Difficulty</u> getting or maintaining <u>erecti</u>ons • <u>Difficulty</u> reaching a <u>climax</u> • Premature <u>ejaculation</u> • Tendency to get <u>lightheaded</u> or faint • <u>Herpes</u> • <u>Genital warts</u> • <u>Epididymitis</u> • <u>Varicocele</u> • <u>HIV</u>
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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 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. I understand there is a deposit of \$100 required to schedule an appointment. I also understand that this deposit will be forfeited if I or any of my representatives change or cancel this appointment with less than 7 days' notice.

Signed: _____ Date: _____