METROVAN UROLOGY
metrovanurology.com
#650 – 6091 Gilbert Road
Richmond, B.C. V7C 5L9
Tel: **604 273 4320**
Fax: 604 273 7599

Previsit Questionnaire

PLEASE PRINT ONLY

Patient's Legal Name: _____
LAST NAME (LEGAL) GIVEN NAMES (LEGAL) PREVIOUS SURNAME(S)

Personal Health Care Number: _____ **Sex:** ☐ Male ☐ Female

Birthdate: Day _____ Month _____Year _____ Marital Status: _____

Your Present Address: _____

City: _____ Province: _____ Postal Code: _____

Which Month & Year Did You Move to the Above Address? _____

Previous Address (if less than 12 months at present address): _____

City: _____ Province: _____ Postal Code: _____

Which Month & Year Did You Move to This Address? _____

Present Employer: _____ Occupation _____

Since: Month _____ Year _____

Next of Kin: Name _____ Relationship _____
LAST NAME GIVEN NAME

Telephone: Please check the best number to contact you at.

(Home) ☐ _____ (Work) ☐ _____

(Cell) ☐ _____ (Other) ☐ _____

Is it OK to contact you on your cell phone? ☐ Yes ☐ No

Is it OK to contact you by email? ☐ Yes ☐ No

(Email): _____

USE OF EMAIL IS RESTRICTED TO SCHEDULING APPOINTMENTS. Please note that no confidential information such as results will be sent by email. We will NOT respond to email with medical questions.

This section only applicable if you are admitted for surgery

Accommodation Preferred (subject to availability only): ☐ Private Room ☐ Semi-Private Room ☐ Standard Ward

There is a Charge for Semi & Private Rooms – Payable on Discharge

Have You Ever Been a Patient in The Richmond Hospital: ☐ No ☐ Yes – when? _____

Urologist: _____ Family Physician: _____

Were You Born in B.C.? ☐ Yes ☐ No **If not, date of arrival in B.C.:** _____

Canadian Citizen? _____ **Landed Immigrant?** _____ **If Landed Immigrant and Have Lived in Canada Less than 1 Year, Photocopy of Immigration Papers Must be Provided Upon Admission.**

Thank you for completing this questionnaire. Email, Print, Fax or Bring to your appointment.

Richmond Hospital
part of the Vancouver Coastal Health Authority

PCIS LABEL

Surgeon:_____

Patient Name:_____ Sex:_____ Date of Birth:_____

Weight:_____lbs./kgs. Height:_____in./cm.

Check [✓] the correct column after each question. PLEASE COMPLETE BOTH SIDES OF THE PAGE.

	Yes	No	Not sure		Yes	No	Not sure
Do you currently have or do you have a history of:				Do you currently have or do you have a history of:			
1. Heart pain / angina				22. Kidney problems / failure			
2. Heart attack				23. Heartburn / hiatus hernia			
3. Heart murmur / heart valve problem				24. Liver disease / jaundice / hepatitis			
4. Stroke				25. Thyroid problems			
5. High blood pressure				26. Arthritis			
6. Irregular pulse				27. Bleeding disorders - yourself			
7. Circulation problems				- other family members			
8. Asthma / bronchitis / emphysema				28. Paralysis / weakness			
9. Shortness of breath with daily activity				29. Numbness of face or limbs			
10. New cough or cold				30. Seizures			
11. Chronic cough				31. Tumors / malignancy			
12. Sleep apnea or use a CPAP machine				32. Previous blood transfusion reactions			
Do you take:				33. Diabetes			
13. Pills for high blood pressure				- If **YES**, circle your treatment: diet only; insulin; pills			
14. Pills to thin your blood				34. Are you, or could you be, pregnant?			
15. Antibiotics before dental work				35. Do you have any other medical problems?			
16. Cortisone-like pills within last 6 months				Do you have:			
Do you:				Dentures	Upper		Lower
17. Smoke tobacco? How much?				Partial plate / dentures	Upper		Lower
18. Have you quit? When?				Capped / loose teeth			
19. Drink alcohol regularly? How much?				Hearing difficulties			
20. Take street drugs? What?				Hearing aid	Right		Left
21. Have you or any member of your family had any problems with anesthetics?				Glasses / contact lens / lens implant / prosthetic eye	Right		Left
Indicate who:							

If **YES** to any of the above questions, please explain: _____

_____

_____

_____

_____

Please turn over and complete Page 2 ➡

Do you have any allergies? Yes ☐ No ☐

Allergy to	Allergic Reaction

Please list all the medications and herbal supplements you take (use a separate piece of paper if you need more space):

Medication / Supplement Name	Dose (amount taken each time)	How often do you take it?	Reason for taking

List any operations you have had:

Date: Operation:

Is there anything else you want us to know about you?

Completed by (please print name): _____ **Date:** _____

If you are not the patient, what is your relationship to the patient? _____

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Male Fertility Questionnaire

Instructions: Please complete **ALL PAGES** of this questionnaire as completely as possible. All information is confidential. In addition to this questionnaire, you should have the following test results forwarded to our office:
1. Results of 2 (two) separate semen analysis performed within the last 3 months
2. Minimum blood tests: follicle stimulating hormone (FSH), testosterone and prolactin drawn *before 930 am*

SPOUSAL INFORMATION

Partners name: _____ Marital Status: _____

Partners birthday: _____ Age _____ Married/together since (year): _____

When did you start attempting to achieve a pregnancy (Month/Year)? _____

Have you seen another urologist for fertility problems? ☐ Yes ☐ No If YES, name: _____

Name(s) of your partner's physicians: Family MD _____ Gynecologist_____

Is it OK if we copy your information to you partner's physicians in order to facilitate her care? ☐ Yes ☐ No

PRIOR PREGNANCIES (including miscarriages and terminations).

Have you had a pregnancy with your **current** partner? ☐ Yes ☐ No If yes, please give date/outcome of pregnancy

_____ _____

_____ _____

Have you had a pregnancy with any **previous** partners? ☐ Yes ☐ No If yes, please give date/outcome of pregnancy

_____ _____

_____ _____

Has your partner had a pregnancy with **previous** partner? ☐ Yes ☐ No If yes, please give date/outcome of pregnancy

_____ _____

_____ _____

What forms of contraception have you used with your current partner (check all that apply):
☐ Condoms ☐ Pills ☐ IUD ☐ Rhythm method ☐ Diaphragm

Thinking back over the past 6 months, approximately how many times per week are you having intercourse? _____
Are you timing intercourse to ovulation? ☐ Yes ☐ No If YES, how are you timing intercourse?
☐ Basal body temperature ☐ Counting days from the onset of menstruation
☐ Change in cervical mucus ☐ Urine ovulation kit

Please indicate the number of siblings you have. Brothers _____ Sisters _____
Do any of your siblings have a history of difficulty achieving a pregnancy? ☐ Yes ☐ No If yes, provide details

_____

_____

Do any members of your family have any of the following conditions? Please check:
☐ Birth defects ☐ Cystic fibrosis ☐ Diabetes ☐ Hormone problems

Do you have sperm banked (cryopreserved) anywhere? Yes ☐ No ☐ If YES, indicate where: _____

PLEASE COMPLETE ALL PAGES

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Male Fertility Questionnaire

Mark [X] the correct column after each question. If YES to any of the below questions, please explain.

	Yes	No	Not Sure		Yes	No	Not Sure
Do you currently have or do you have a history of:				Do you take or have you taken in the past:			
1. Fever > 38C (101 ˚F) in the past 6 months				30. Anabolic steroids for bodybuilding			
2. Regular use of a hot tub, sauna or hot bath				31. Allopurinol			
3. Use lubricants for intercourse				32. Antidepressants/antipsychotics			
4. Problems with erections *				33. Antihypertensives			
5. Problems with ejaculation				34. Antiparasitic agents			
6. Blood in your ejaculate/semen				35. Barbituates			
7. Blood in your urine				36. Cimeditine			
8. Vasectomy				37. Chemotherapy for cancer			
9. Vasectomy reversal				38. Cholesterol lowering drugs			
10. Varicocele repair				39. Clomid (clomiphene)			
11. Testicular torsion				40. Dilantin			
12. Surgery for undescended testes				41. Hormones			
13. Other types of scrotal surgery				42. Immunosuppressant drugs			
14. Inguinal/hernia surgery (which side?)				43. Insulin			
15. Difficulty with urination *				44. Prostate medications			
16. Difficulty with bowel movements				45. Ranitidine			
17. Problem with your vision (not incl. glasses)				46. Any exposure at work to toxic chemicals			
18. Problems with your sense of smell				47. Radiation treatment			
19. How many alcoholic drinks per week?				Have you and your partner undergone any of the following treatments: If yes, enter the number of times for each			
20. Tobacco smoking. How much?				48. Undergone prior assisted reproductive treatments? If so, check below:			
21. Marijuana smoking				49. Hormonal treatment			
22. Any other ‘street drugs’				50. Intrauterine insemination			
Do you have a history of infection of the urinary or genital tract?:				51. In vitro fertilization (IVF)			
23. Bladder infection (cystitis)				52. Had a scrotal ultrasound			
24. Prostate infection (prostatitis)				Has your PARTNER had:			
25. Testis infection (orchitis)				53. A sexually transmitted infection			
26. Mumps after the onset of puberty				54. Pelvic inflammatory disease			
27. Gonorrhea				55. Endometriosis			
28. Chlamydia				56. Uterine fibroids			
29. Herpes				57. Any abdominal or pelvic surgery			
30. Other: indicate below				58. A hysterosalpingogram			
Do you take or have you taken in the past:				59. Her hormones checked			
31. Acyclovir				60. Irregular periods/menstruation			

* If you have problems with erections, complete IIEF form; if problems with urination, complete IPSS form

Is there anything else that you want us to know about you or which you think might affect your ability to have children?

PLEASE COMPLETE ALL PAGES