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VASECTOMY REVERSAL QUESTIONNAIRE

LAST Name (REQUIRED) ________ FIRST Name (REQUIRED) ________ PHN/CARE CARD NUMBER (REQUIRED) ________

Date ________

Instructions: Please complete this questionnaire as completely as possible.
All information is strictly confidential and will assist in your evaluation.

In what year did you have your vasectomy? ___________ How many children do you have? _______

How many children would you like **AFTER** reversal? _______ Age of the youngest child? __________

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

	Yes	No	Not Sure		Yes	No	Not Sure
RELEVANT HISTORY If YES, specify side				**UROLOGIC REVIEW**			
1. Undescended testes				13. Family history of PROSTATE cancer			
2. Circle side(s) RIGHT LEFT				14. Kidney stones			
3. Scrotal surgery (e.g. hydrocele)				15. Bladder infections			
4. Circle side(s) RIGHT LEFT				16. Chlamydia			
5. Inguinal hernia surgery				17. Gonorrhea			
6. Circle side(s) RIGHT LEFT				18. Blood in the urine (hematuria)			
7. Pain in your scrotum				19. Erection problems			
8. Circle side(s) RIGHT LEFT				20. Bladder or prostate surgery			
CONTRACEPTION				**URINARY SYMPTOMS**			
9. Rhythm method				21. Slow stream			
10. Condoms				22. Stream that starts and stops			
11. Oral contraception (“the pill”)				23. Urinate at night more than twice (2x)			
12. Intrauterine device				24. More frequent urination than usual			
				25. Incomplete bladder emptying			
				26. Difficulty postponing urination			

PARTNER INFORMATION - In order to determine if vasectomy reversal is for you, it is important to know some details about your partner’s status.

Partners Name ______________________________ Partner’s Date of Birth ______________________

	Yes	No	Not Sure		Yes	No	Not Sure
FERTILITY HISTORY				**GYNECOLOGIC HISTORY**			
Has she had children with you				Any abdominal or pelvic surgery			
Has she had children with another partner				Sexually transmitted infection			
Hysterosalpingogram				Pelvic inflammatory disease			
Her hormones checked				Endometriosis			
Irregular periods/menstruation				Uterine fibroids			

If you answered YES to any of the above, please explain. Anything else that you think is important for us to know?

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PLEASE COMPLETE ALL PAGES