METROVAN UROLOGY
metrovanurology.com
#650 – 6091 Gilbert Road
Richmond, B.C. V7C 5L9
Tel: **604 273 4320** (24 hrs)
Fax: 604 273 7599

VASECTOMY 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.

FERTILITY HISTORY

How many children do you have? _____ What is the age of the youngest child? _____

Age of current partner? _____

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
RELEVANT HISTORY If YES, specify side				**UROLOGIC REVIEW**			
1. Undescended testes.				17. Family history of PROSTATE cancer			
2. RIGHT				18. Kidney stones			
3. LEFT				19. Bladder infection			
4. Scrotal surgery (e.g. hydrocele)				20. Chlamydia			
5. RIGHT				21. Gonorrhea			
6. LEFT				22. Blood in the urine (hematuria)			
7. Inguinal hernia surgery.				23. Erection problems			
8. RIGHT				24. Bladder or prostate surgery			
9. LEFT				**URINARY SYMPTOMS**			
10. Pain in your scrotum.				25. Burning			
11. RIGHT				26. Slow stream			
12. LEFT				27. Stream that starts and stops			
CONTRACEPTION				28. Urinate at night more than twice (2x)			
13. Rhythm method				29. More frequent urination than usual			
14. Condoms				30. Incomplete bladder emptying			
15. Oral contraception (“the pill”)				31. Difficulty postponing urination			
16. Intrauterine device				32. Leakage (incontinence)			

Explain if you answered YES to any of the above. Is there anything else that you think is important for us to know?

_____

_____

_____

_____

PLEASE COMPLETE ALL PAGES