

MEDICAL HISTORY FOR VASECTOMY

Please complete and circle answer where necessary

1. NAME _____

2. AGE _____ WEIGHT (kg) _____ HEIGHT (cm) _____

3. Do you have any children? YES NO (If NO, go to 5)

4. What are the ages and sexes of your children? _____

5. If applicable, is your partner currently pregnant? YES NO

6. What form of contraception do you or your partner currently use? _____

7. Are you? **married de facto single divorced separated widowed other**

8. If applicable, how many children do you currently support? _____

9. Do you have any desire to have more children in the future? YES NO

10. Do you feel that your family is complete? YES NO

11. Does your partner feel that her family is complete? YES NO

12. Have you had any prior surgery requiring an anaesthetic? YES NO

13. What operations have you had?

14. Have you had any complications from surgery or anaesthetics? YES NO

Please explain _____

15. Do you have or have had any of these medical problems or surgical problems?

Asthma sleep apnoea gastric reflux diabetes epilepsy
high blood pressure heart problems heart murmurs bleeding problems
Hepatitis B Hepatitis C sexually transmitted infections
testicular infections varicocele hydrocoele surgery on undescended testicle
hernia repair depression anxiety other _____

16. Can you climb a set of stairs without breathlessness? YES NO

17. Can you walk 2 blocks on level ground without breathlessness? YES NO

18. Do you take any medications? YES NO (If NO, go to 20)

19. What medications do you take? _____

20. Do you have any allergies? _____

21. Do you smoke cigarettes? YES NO (If NO, go to 23)

22. How many cigarettes do you smoke? _____

Please turn over

23. Do you drink alcohol? **YES NO** (If NO, go to 25)
24. How often do you drink? **Every Day >once/ week weekends monthly**
25. Do you take any other recreational drugs? **YES NO** (If NO, go to 27)
26. How often do you use other drugs? **Everyday once/week weekend monthly**
27. When was the last time you ate or drank anything? _____
28. How are you getting home today? _____
29. Is someone taking you home today? **YES NO**
30. What is the first name of your support person? _____
31. Contact phone number of support person? _____
32. Would you like this person to join you in recovery after the procedure? **YES NO**
33. Are there any questions that you would like to ask the doctor? _____
- _____
- _____
- _____
34. Briefly describe your reasons for choosing vasectomy as your method of contraception _____
- _____
- _____
- _____
35. Are you sure of your decision to have permanent contraception? **YES NO**
Remember there is no guarantee that a vasectomy can be reversed, so if you think you may change your mind, then you and your partner should use another form of contraception.

ALL INFORMATION IS TREATED CONFIDENTIALLY.

AFTER COMPLETING THIS FORM AND READING THE COMPREHENSIVE INFORMATION ABOUT VASECTOMY, YOU WILL HAVE A CONSULTATION WITH THE DOCTOR AND WILL HAVE AN OPPORTUNITY TO ASK QUESTIONS.
 YOU ARE UNDER NO OBLIGATION TO HAVE THE PROCEDURE PERFORMED TODAY IF YOU ARE NOT READY.