Vasectomy and Male Infertility Center of Connecticut

Vasectomy Reversal Patient Intake Form

Name: _____

Date: _____

Primary MD: _____

Referring MD: _____

Partner's Full Name: _____

Partner's DOB: _____

How heard about Dr. Matson:

Doctor Friend Radio Internet Wife

Height _____ Weight_____

Please list all medical conditions:

None

1. _____
2. _____
3. _____

Please list all medications taken daily:

None

1. _____
2. _____
3. _____

Please list all surgeries you have had:

None

1. _____ Date_____
2. _____ Date_____
3. _____ Date_____

Please list family illnesses and relationship:

None

1. _____Relative_____
2. _____Relative_____
3. _____Relative_____

Please list all allergic triggers and reaction:

None

1. _____Reaction_____
2. _____Reaction_____
3. _____Reaction_____

Current type of work/profession:

_____

Year of Vasectomy: _____

Where Vasectomy Performed:

_____

Current Marital status:

Single Married Divorced Remarried

Age of partner: _____

Has your partner ever conceived: Y / N

If so how many times? _____

If so how many children does she have? _____

Number of biological children: _____

Age_____ M / F

Age_____ M / F

Age_____ M / F

Age_____ M / F

Age_____ M / F

Do you use alcohol (circle)?

None Social/Rare Daily _____ (drinks per day)

Do you smoke (circle)?

NO YES Packs per day_____

Do you use chewing tobacco? Y / N

Have you had injury/surgery/trauma to testicle area?

NO YES: _____

Have you ever had epididymitis? (painful swelling of one of the testicles? Y / N

Do you experience any symptoms in the following body areas (circle any)?

Head Neck Chest Abdomen Legs Arms Skin

Do you have any symptoms with the following body systems/functions (circle any)?

Brain/Neurologic Vision Heart Lungs Intestinal

Kidney/Bladder Sexual Vascular Muscular Skeletal

Blood/Clotting Psychiatric Other: