Vasectomy and Male Infertility Center of Connecticut

Vasectomy Patient Intake Form

Name: ________________________________

Today's Date: __________________________

Primary MD: ___________________________

Partners Full Name: _____________________

Partners DOB: __________________________

Pharmacy & Address:

____

How did you hear about Dr. Matson?

Doctor Friend Radio Internet Wife

Your Hight _______ **and Weight**________

Please list all medical conditions:

None

1. ________________________________
2. ________________________________
3. ________________________________

Please list all medications taken daily:

None

1. ________________________________
2. ________________________________
3. ________________________________

Please list all lifetime 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_________________

Do you have a history of fainting? Y / N

Current type of work/profession:

____

Marital status:

Single Married Divorced Remarried

Age of current partner: ______

Is your significant other pregnant: Y / N

Number of biological children: _____

Age_______ M / F

Age_______ M / F

Age_______ M / F

Age_______ M / F

Age_______ M / F

Number of stepchildren: _____

Age_______ M / F

Age_______ M / F

Age_______ M / F

Age_______ M / F

Current birth control method: ____________________

Do you use alcohol (circle)?

None Occasional Moderate Heavy

Have you used tobacco/chew/vaping daily in the past?

Never Former Current Packs/day____ # of Years ____

Do you use drugs including marijuana? Y / N

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

NO YES: _______________________

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: