Wazektomia.com
nowoczesna antykoncepcja dla mężczyzn

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PATIENT SURVEY

Please answer all the questions on this page (questions with * are not obligatory). It is important that we have accurate knowledge of your background, medical history, reproductive history, and future plans and expectations in order to best serve you.

Your full name
Age Education/grade
Occupation
Your marriage 1 2 3 Other

Wife/partner's name (*)
Age Education/grade
Occupation
Your marriage 1 2 3 Other

Years in relationship Do you consider this relationship permanent? Y N

	1	2	3	4	5	6
Children Age						
Sex: Male/Female						
Ours/Mine/Hers/Adopted						
Living with me: Yes/No						

Do you wish to have more children in the future? Yes/No/Uncertain Y N ?
Would you consider adoption if you chose to have more children? Y N
For how long have you considered vasectomy?
Have you considered tubal ligation as an alternative sterilization choice? Y N
Have you considered temporary birth control methods (condoms, diaphragm)? Y N

ZIndicate your current X and prior methods of birth control:

Abstinence None Condoms Diaphragm IUD Pill Patch
Contraceptive injections Other

Does vasectomy conflict with your religion? Y N
Do you have or does your partner have any sexual problems or concerns? Y N
Are you choosing vasectomy because of a health or genetic issue with you or your wife Y N
because of my health Y N
because of my wife's health Y N
What do you consider to be your current state of health? Good / Fair / Poor G F P
*Have you ever experienced a mental illness, or depression? (*) Y N
Do you think you are more sensitive to pain than the average person? Y N
Have you fainted with a medical procedure? Y N
Do you or anyone in your family have a bleeding tendency? Y N
Do you have a kidney abnormality or abnormal kidney function? Y N
Have you had prostatitis, epididymitis, gonorrhea, chlamydia, hepatitis, AIDS? Y N
Have you ever had a hernia, infection, tumor, or abnormality of the scrotum or testes? Y N
Have you ever had a serious injury or surgery to the testicles or scrotal area? Y N

List all surgeries you have had:

Did you have any complications or excessive pain or bleeding after surgery? Y N

Name all medicines you have taken in the last two weeks

Are you using aspirin products within the 5 days before your procedure? Yes No Y N

List any allergy to a drug, medication, or anesthetic

List all major illnesses you have had

Date and Patient's Signature