

## Health Questionnaire

Please answer each of the questions on this page. 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.

ID: \_\_\_\_\_

1. Your name \_\_\_\_\_
2. Your age: \_\_\_\_\_ 3. Education/grade: \_\_\_\_\_
4. Your occupation \_\_\_\_\_
5. Your marriage:  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup> other \_\_\_\_\_
6. Wife/partner's name \_\_\_\_\_
7. Her age: \_\_\_\_\_ 8. Education/grade: \_\_\_\_\_
9. Her occupation \_\_\_\_\_
10. Her marriage:  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup> other \_\_\_\_\_
11. Years in this relationship: \_\_\_\_\_ 12. Do you consider this relationship permanent?  Yes  No

13. Children:	1	2	3	4	5	6
Age:						
Sex: Male / Female	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Ours / Mine / Hers / Adopted						
Living with me: Yes / No	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

14. Do you wish to have more children in the future?  Maybe  Yes  No
15. Would you consider adoption if you chose to have more children?  Yes  No
16. For how long have you considered vasectomy? \_\_\_\_\_
17. Have you considered tubal ligation as an alternative sterilization choice?  Yes  No
18. Have you considered temporary birth control methods (condoms, diaphragm)?  Yes  No
19. Indicate your current and prior methods of birth control:  
 Abstinence  Condoms  Diaphragm  IUD  Patch  Pill  Shot  None  Other \_\_\_\_\_
20. Does vasectomy conflict with your religion?  Yes  No
21. Do you have or does your partner have any sexual problems or concerns  Yes  No
22. Are you choosing sterilization because of a health or genetic issue with you or your wife?  Yes  No
23. What do you consider to be your current state of health?  Good  Fair  Poor
24. Does mental illness or depression affect your decision making?  Yes  No
25. Do you think you are more sensitive to pain than the average person?  Yes  No
26. Have you fainted with a medical procedure?  Nearly  Yes  No
27. Do you or anyone in your family have a bleeding tendency?  Yes  No
28. Do you have a kidney abnormality or abnormal kidney function?  Yes  No
29. Have you had prostatitis, epididymitis, gonorrhea, chlamydia, hepatitis, AIDS?  Yes  No
30. Have you ever had a hernia, infection, tumor, or abnormality of the scrotum or testes?  Yes  No
31. Have you ever had a serious injury or surgery to the testicles or scrotal area?  Yes  No
32. List all surgeries you have had: \_\_\_\_\_
33. Did you have any complications or excessive pain or bleeding after surgery?  Yes  No
34. Name all medicines you have taken in the last two weeks: \_\_\_\_\_
35. Are you using aspirin products within the five days of your procedure?  Yes  No
36. List any allergy to a drug, medication, or anesthetic: \_\_\_\_\_
37. List all major illnesses you have had: \_\_\_\_\_