

Vasectomy and Male Infertility Center of Connecticut

Vasectomy Patient Intake Form

Name: _____

Date: _____

Primary MD: _____

Referring MD: _____

How heard about Dr. Matson:

Doctor Friend Radio Internet Wife

Please list all medical conditions:

None

1. _____

2. _____

3. _____

4. _____

Please list all medications taken daily:

None

1. _____

2. _____

3. _____

4. _____

Please list all surgeries you have had:

None

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

4. _____ 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:

Marital status:

Single Married Divorced Remarried

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

Age _____ M / F

Current birth control method: _____

Do you use alcohol (circle)?

None Social/Rare Daily _____ (drinks per day)

Do you smoke (circle)?

NO YES Packs per day _____

Is your significant other pregnant: 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: