VASECTOMY AND MALE INFERTILITY CENTER OF CONNECTICUT

VASECTOMY PATIENT INTAKE FORM

Referring MD:	Name:		Current type of work/profession:	
Referring MD:				
How heard about Dr. Matson: Doctor Friend Radio Internet Wife Describited Radio Internet Wife Doctor Friend Radio Internet Wife Doctor Friend Radio Internet Wife Doctor Friend Radio Internet Wife Significant other pregnant: Y /N I	Primary MD:		Marital status:	
Doctor Friend Radio Internet Wife Please list all medical conditions: None 1	Referring MD:		Single Married Divorced Remarried	
Please list all medical conditions: None 1	How heard about Dr. Matson:		Number of biological children:	
None	Doctor Friend Radio Internet Wife		0	
1.	Please list all medical conditions:		Significant other pregnant: Y /N	
3	None		1 AgeM / F	
3	1		2 AgeM/F	
S Age M / F	2		$3 Age _ M / F$	
Please list all medications taken daily: Number of stepchildren: Number of stepchildren:	3		4 AgeM / F	
None 1.	4		5 AgeM/F	
1	Please list all medications taken daily:		Number of stepchildren:	
2 AgeM/F 3	None		0	
2	1		1 Age M / F	
3			2 Age M / F	
4 AgeM/F Please list all surgeries you have had: 5 AgeM/F Current birth control method: 1DateDoteNone Social/Rare Daily(drinks per day) 3DateDoteNone Social/Rare Daily(drinks per day) 4DateNo YES Packs per dayHave you had injury/surgery/trauma to testicle area? NO YES: NO YES: NO YES: Please list family illnesses and relationship: None 1RelativeNo 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)? Please list all allergic triggers and reaction: None ReactionBrain/Neurologic Vision Heart Lungs Intestinal Kidney/Bladder Sexual Vascular Muscular Skeletal Blood/Clotting Psychiatric Other:			3 AgeM/F	
Please list all surgeries you have had: Social Rare Date Do you use of alcohol (circle)?			4 Age M / F	
Do you use of alcohol (circle)? Date	Please list all surgeries you have had:		5 AgeM/F	
2	None		Current birth control method:	
Do you smoke (circle)? Do you smoke (circle)? NO YES Packs per day	1	Date	Do you use of alcohol (circle)?	
A Date NO YES Packs per day	2	Date	None Social/Rare Daily (drinks per day)	
Please list family illnesses and relationship: None 1Relative			Do you smoke (circle)?	
None 1Relative	4	Date	NO YES Packs per day	
Do you experience any symptoms in the following body areas (circle any)? 2Relative	Please list family illnesses and relationship:		Have you had injury/surgery/trauma to testicle area?	
Do you experience any symptoms in the following body areas (circle any)? Relative	None		NO YES:	
2Relative		Relative		
3Relative			· · · · · · · · · · · · · · · · · · ·	
4Relative			•	
Please list all allergic triggers and reaction: None Kidney/Bladder Sexual Vascular Muscular Skeletal Reaction Reaction Reaction Reaction				
1ReactionBlood/Clotting Psychiatric Other: 2Reaction			Brain/Neurologic Vision Heart Lungs Intestinal	
1ReactionBlood/Clotting Psychiatric Other: 2Reaction	None		Kidney/Bladder Sexual Vascular Muscular Skeletal	
2Reaction		Reaction		
			Blood/Clotting Psychiatric Other:	
J. Reaction Rev 5/11			Rev 5/11	