VASECTOMY REVERSAL EVALUATION QUESTIONNAIRE

DATE: _____

NAME: _____ AGE: _____ SS# ____/_____/_____

MARRIED: YES NO YEARS MARRIED: _____

YEAR VASECTOMY WAS PERFORMED: _____

PRIOR PREGNANCIES IN THIS MARRIAGE: YES NO

IF YES, NUMBER OF CHILDREN AND AGES: _____

PRIOR PREGNANCIES WITH OTHER PARTNERS:

WIFE: YES NO AGES OF CHILDREN: _____

HUSBAND: YES NO AGES OF CHILDREN: _____

HOW MANY MORE CHILDREN DO YOU WANT? _____

QUESTIONS FOR MALE:

PRIOR MALE EVALUATION:

List the results of any semen analysis, medical or surgical therapy for infertility:

_____
_____
_____
_____

Did puberty occur abnormally late or early during adolescence: YES NO

RISK FACTORS:

Occupation: _____

Did you ever have the following:

1. Mumps in the testicles: YES NO
2. An infection in the testicles: YES NO
3. An undescended testicle: YES NO
4. Damage or injury to the testicles: YES NO
5. Recent high fever: YES NO
6. Sexually transmitted diseases: YES NO
   (Gonorrhea, Syphilis, Chlamydia, Trichomonas)
7. Prostate infections: YES NO
8. Tuberculosis: YES NO

If you don't know the answers to the following questions, ask your mother, her doctor, or the hospital where you were born if possible:

9. Did your mother have any difficulties (spotting or miscarriages) with any of her pregnancies?
   YES NO Don't know
10. Did your mother have any difficulties while she was carrying you?
    YES NO Don't know
11. Did your mother take DES while she was pregnant with you?
    YES NO Don't know
12. Did your mother take any other hormonal medication while she was pregnant with you?
    YES NO Don't know

Are you exposed to:

1. Pesticides (other than routine use in the home or yard): YES NO
2. Radiation or X-Rays (other than normal chest X-Rays, etc): YES NO
3. Heat (including regular use of a hot tub, bathtub, (not showers) YES NO
   Jacuzzi, steam room, sauna)
4. Drugs (marijuana, chemotherapy, steroids): YES NO
   If so List

   _____
   _____
   _____

How much alcohol do you consume? None / 1-2 per day / 3 or more per day

Do you smoke? YES NO

If yes, how many packs per day? _____

MEDICAL HISTORY:

Medical Illnesses:

Surgeries:

PRIOR VARICOCELE SURGERY: YES NO
PRIOR TESTIS BIOPSY: YES NO
PRIOR VASECTOMY REVERSAL: YES NO

Medication:

Allergies to Medications:

FAMILY HISTORY:

Any fertility problems in brothers or sisters?

_____
_____

Any history of cystic fibrosis?

_____
_____

SEXUAL HISTORY

1. Frequency of intercourse: _____ times per week
2. Lubrication used: _____ / NONE
3. Masturbation: _____times per month
4. Are you able to obtain erections adequate for intercourse? YES NO
5. Do you ejaculate with intercourse? YES NO
6. Does your wife usually have pain with intercourse? YES NO

REVIEW OF SYSTEMS

ENT			**RESPIRATORY**		
Frequent sinus Infection	YES	NO	Chronic Cough	YES	NO
Difficulty Smelling	YES	NO	Shortness of Breath	YES	NO
CARDIOVASCULAR			**EYES**		
Chest Pain	YES	NO	Difficulty with vision (other than routine glasses)	YES	NO
Heart Murmur	YES	NO	Double Vision	YES	NO
Artificial Valve	YES	NO			
NEUROLOGICAL			**HEMATOLOGIC**		
Frequent severe headaches	YES	NO	Blood Clotting Problem	YES	NO
Seizures	YES	NO	Swollen Glands	YES	NO
Numbness or weakness in extremities	YES	NO			
ENDO			**GU**		
Breast enlargement or milk production from breasts	YES	NO	Burning/Blood with urination	YES	NO
			Poor urinary stream	YES	NO
GI			**CONSTITIUTIONAL**		
Abdominal Pain	YES	NO	Significant weight loss	YES	NO
Nausea/Vomiting	YES	NO	Fever	YES	NO

Other Medical Problems: _____

_____

PFSH: QUESTIONS FOR FEMALE

Name: _____ Age: _____

Name of Gynecologist: _____

Circle and List results of any of the following test that have been performed:'

1. BBT (Basil Body Temperature)
2. PCT (Post Coital Test)
3. HSG (Hysterosalpingogram)
4. Laparoscopy
5. Endometrial Biopsy
6. Urine testing for ovulation
7. Ovarian ultrasound
8. List any other testing and treatment

_____
_____
_____
_____

AUTHORIZATION FOR ASSIGNMENTS OF BENEFITS

MEDICARE PATIENTS PLEASE SIGN HERE:

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made either to me or on my behalf for any services furnished to me by University Urological Associates, Inc. Including physician services. I authorize any holder of medical or other information and its agents any information needed to determine these benefits or benefits for related services.

SIGNATURE: _____

DATE: _____

BLUE CROSS/BLUE SHIELD PATIENTS PLEASE SIGN HERE:

I request that payment of authorized Blue Shield benefits made on my behalf for any services furnished on me by or in the name of University Urological Associates Inc. including physician services. I acknowledge that if my coverage is under plans "A" or "B" or the low-option Federal Employee Program that the services provisions have been explained to me.

SIGNATURE: _____

DATE: _____

PRIVATE INSURANCE PATIENTS PLEASE SIGN HERE:

I hereby request payment of medical benefits either to myself or to the doctor or party who accepts assignment. I hereby authorize University Urological Associates, Inc. to release any information require in the course of my examination and treatment.

SIGNATURE: _____

DATE: _____

OFFICE AND LABORATORY – PATIENT REGISTRATION

DATE:_____

PATIENT

ACCOUNT#: _____

NAME: _____ AGE:_____DOB:_____

ADDRESS: _____CITY_____STATE/ZIP_____

PHONE#_____CELL PHONE #_____SS#____/____/_____

ALLERGIES TO MEDICATION: NO YES/LIST:_____

SINGLE:_____ MARRIED:_____ DIVORCED: _____ WIDOWED:_____

EMPLOYED BY: _____OCCUPATION:_____

ADDRESS:_____PHONE#_____

SPOUSE/PARTNER

ACCOUNT# _____

NAME: _____ AGE: _____DOB:_____

ADDRESS: _____CITY_____STATE/ZIP_____

PHONE#_____CELL PHONE #_____SS#_____/____/_____

ALLERGIES TO MEDICATION: NO YES/LIST:_____

EMPLOYED BY: _____ OCCUPATION:_____

ADDRESS: _____ PHONE# _____

PRIMARY CARE PHYSICIANS: _____

ADDRESS: _____ PHONE# _____

REFERRING PHYSICIAN: _____

ADDRESS: _____ PHONE # _____

PHARMACY: _____ ADDRESS:_____ PHONE# _____

PATIENT

PRIMARY INSURANCE**:** _____POLICY HOLDER' NAME _____

GROUP# _____ POLICY # _____

SECONDARY INSURANCE: _____ POLICY NAME: _____

GROUP # _____ POLICY # _____

SPOUSE /PARTNER

PRIMARY INSURANCE**:** _____POLICY HOLDER' NAME _____

GROUP# _____ POLICY # _____

SECONDARY INSURANCE: _____ POLICY NAME: _____

GROUP # _____ POLICY # _____