Date:________________________________

Patient MR #: ________________________

EVALUATION FORM
FOR VASECTOMY
UT ERLANGER UROLOGY

Name ____

Age ____

Date of Birth ____

Your Occupation____

Employer____

Religion ____

How did you hear about our services? ______________________________

Previous impregnation number ______________________________

SEXUAL HISTORY

Erectile Difficulty	Yes	No
Ejaculatory Difficulty	Yes	No
Loss/change in libido (sex drive)	Yes	No

CHILDHOOD AND DEVELOPMENT

Age of onset of puberty ______________________________

Testicular torsion/trauma	Yes	No

MEDICAL HISTORY

Heart Disease	Yes	No
Heart Murmur	Yes	No
Hypertension	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No

If yes, type and treatment ______________________________

Other ____

SURGICAL HISTORY (if yes, specific procedure and diagnosis)

Orchidopexy (surgical repair of undescended testicle)	Yes	No
Orchiectomy (surgical removal of testicle)	Yes	No

If yes, diagnosis ____________________

Hernia repair	Yes	No
Pelvic surgery	Yes	No
Scrotal surgery	Yes	No
Retroperitoneal surgery (involving abdominal organs)	Yes	No

Other ____________________

INFECTIONS (if yes, when and how was it treated)

Gonorrhea	Yes	No
Chlamydia	Yes	No
Syphilis	Yes	No
Herpes	Yes	No
Mumps	Yes	No
Prostatis	Yes	No
Urethritis	Yes	No
Cystitis (bladder infection)	Yes	No
Pyelonephritis (kidney infection)	Yes	No
Epididymitis (testicle infection)	Yes	No

Other ____________________

MEDICATION/CHEMICAL/ENVIRONMENTAL EXPOSURE

Prescription medications Yes No

If yes, name and dosage ____________________

Drug Allergies Yes No

If yes, name of drug ____________________

Alcohol Yes No

If yes, how much and how often ____________________

Marijuana Yes No

If yes, how much and how often ____________________

Other drugs Yes No

If yes, how much and how often ____________________

Tobacco Yes No

If yes, how much and how often ____________________

FAMILY HISTORY (if yes, who in family affected)

Heart diseas	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
Genetic disease	Yes	No

REVIEW OF SYSTEMS

Have you had any of the following:

Constitutional – weight change, weakness, fever, fatigue, chills	Yes	No
Cardiovascular – high blood pressure, murmurs, chest pain	Yes	No
Respiratory – cough, shortness of breath, asthma, bronchitis	Yes	No
Gastrointestinal – difficulty swallowing, heartburn, nausea, vomiting	Yes	No
Genitourinary – hematuria, frequency, urgency, discharge, lumps	Yes	No
Musculoskeletal – muscle or joint pain, stiffness, arthritis	Yes	No
Skin/Breasts – rashes, itching, lumps, sores, color change	Yes	No
Hematological/Lymphatic- anemia, easy bruising	Yes	No
Allergic/Immunologic – immunizations, allergies, HIV testing	Yes	No

If you answered YES to any of the above please explain them below: ____

____

____

____

PHYSICAL EXAM

HEENT normal		Yes	No
If no, describe abnormalities ______			
Lymphadenopathy		Yes	No
Lungs clear		Yes	No
Heart regular rate/rhythm		Yes	No
Abdomen			
Tender		Yes	No
Masses (liver/spleen)		Yes	No
Scars		Yes	No
Hernia		Yes	No
Penis			
Circumcised		Yes	No
Meatus normal		Yes	No
Plaques/curvature		Yes	No
Testes			
Descended		Yes	No
Number		______	
Size (vol. or cm		______	
Masses		Yes	No
Tender		Yes	No
Epididymis			
Present		Yes	No
Indurated/tender		Yes	No
Spermatic cord			
Vas present		Yes	No
Vassal defects	Right/Left ______		
Granulomas		Yes	No
Varicocele		Yes	No
If yes, how big	Small	Medium	Large
Rectal			
Prostate size		______	
EPS		Yes	No
Seminal vesicles palpable		Yes	No
Extremities intact		Yes	No
Neurologic exam intact		Yes	No