Date:_____

Patient MR #:_____

EVALUATION FORM
FOR VASECTOMY REVERSAL

UT ERLANGER MEN'S HEALTH

Name_____

Age_____

Date of Birth_____

Occupation _____

Religion _____

How did you hear about our services?

_____

Previous impregnation number

_____

When did you have your vasectomy?

_____

Prior evaluation Yes No

If yes, prior test results

_____

If yes, treatment and results

_____

SEXUAL HISTORY

Erectile Difficulty Yes No

Ejaculatory Difficulty Yes No

Loss/change in libido (sex drive) Yes No

CHILDHOOD 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
Prostatitis	Yes	No
Urethritis	Yes	No
Cystitis (bladder infection)	Yes	No
Pyelonephritis (kidney infection)	Yes	No
Epididymitis/orchitis (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 is family affected)

Heart disease 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 answered YES to any of the above please explain them below

_____

_____

_____

FEMALE INFORMATION

Age_____

Date of Birth_____

Occupation _____

Age of onset of menses _____

Menstrual cycle: every _____ days Flow: Heavy Medium Light

Length of menses (# of days)_____

Cycles regular Yes No

Previous pregnancy Yes No

If yes, number, year and number of deliveries

_____

Infertility evaluation Yes No

If yes, what tests and results

_____

PHYSICAL EXAM

Lymphadenopathy 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
- Vasal defects Right/Left
- Granulomas Yes No
- Varicocele Right/Left Yes No
- If yes, how big Small Medium Large

RectalProstate size

_____

- EPS Yes No

Seminal vesicles palpable Yes No