



Health Questionnaire

Please answer each of the questions on this page. It is important that we have accurate knowledge of your background, medical history, reproductive history, and future plans and expectations in order to best serve you.

1. Your name _____ 6. Wife/partner's name _____
 2. Your age: _____ 3. Education/grade: _____ 7. Her age: _____ 8. Education/grade: _____
 4. Your occupation _____ 9. Her occupation _____
 5. Your marriage: 1st 2nd 3rd other _____ 10. Her marriage: 1st 2nd 3rd other _____
 11. Years in this relationship: _____ 12. Do you consider this relationship permanent? Yes No

13. Children:	1	2	3	4	5	6
Age:						
Sex: Male / Female	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Ours / Mine / Hers / Adopted	_____	_____	_____	_____	_____	_____
Living with me: Yes / No	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

14. Do you wish to have more children in the future? Yes No Uncertain
 15. Would you consider adoption if you chose to have more children? Yes No
 16. For how long have you considered vasectomy? _____
 17. Have you considered tubal ligation as an alternative sterilization choice? Yes No
 18. Have you considered temporary birth control methods (condoms, diaphragm)? Yes No
 19. Indicate your current and prior methods of birth control:
Abstinence NONE Condoms Diaphragm IUD Pill Patch Shot Other _____
 20. Does vasectomy conflict with your religion? Yes No
 21. Do you have or does your partner have any sexual problems or concerns? Yes No
 22. Are you choosing sterilization because of a health or genetic issue with you or your wife? Yes No
 23. What do you consider to be your current state of health? GOOD FAIR POOR
 24. Does mental illness or depression affect your decision making? Yes No
 25. Do you think you are more sensitive to pain than the average person? Yes No
 26. Have you fainted with a medical procedure? Nearly Yes No
 27. Do you or anyone in your family have a bleeding tendency? Yes No
 28. Do you have a kidney abnormality or abnormal kidney function? Yes No
 29. Have you had prostatitis, epididymitis, gonorrhea, chlamydia, hepatitis, AIDS? Yes No
 30. Have you ever had a hernia, infection, tumor, or abnormality of the scrotum or testes? Yes No
 31. Have you ever had a serious injury or surgery to the testicles or scrotal area? Yes No
 32. List all surgeries you have had: _____
 33. Did you have any complications or excessive pain or bleeding after surgery? Yes No
 34. Name all medicines you have taken in the last two weeks: _____
 35. Are you using aspirin products within the 5 days before your procedure? Yes No
 36. List any allergy to a drug, medication, or anesthetic: _____
 37. List all major illnesses you have had: _____