VASECTOMY CLINIC OF SAN DIEGO

Please fill out all *Required Fields.

PERSONAL INFORMATION

*Last Name: ______________________ *First Name: ______________________

*Date of Birth: ______________________ Age: __________

CONTACT INFORMATION

*Address Line 1: ______________________

Address Line 2: ______________________

*City: ______________________ *State: ______________________

*Country: ______________________ *Zip Code: ______________________

*Please provide phone numbers and select the box of the preferred number to use:

☐ Home Phone: __________ ☐ Work Phone: __________ ☐ Cell Phone: __________

*Email Address: ______________________

OCCUPATION

*Job Title: ______________________

*Level of Exertion at work: ☐ Light ☐ Medium ☐ High

Explain: ______________________

FAMILY

*Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

*Number of Children: ______________________

If youngest child is less than 2 years state age: ______________________

If youngest child is older than 2 years state age: ______________________

MEDICAL HISTORY

*Have you ever been diagnosed with any medical condition (diabetes, Hepatitis C, HIV, etc.)?

☐ Yes ☐ No Please Describe: ______________________

*Are you on any prescription medications (including inhalers, insulin, etc.)?

☐ Yes ☐ No Please Describe: ______________________

*Are you allergic to any medications?

☐ Yes ☐ No Please Describe: ______________________

*Do you have any problems with local anesthetics (freezing) at the dentist?

☐ Yes ☐ No Please Describe: ______________________

*Do you have any bleeding problems or take any medication (Aspririn or Coumadin) that promote bleeding?

☐ Yes ☐ No Please Describe: ______________________

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*Have you ever had surgery to the scrotum / testicles including, but not limited to, undescended testicles, torsion of the testicles, hydrocele, varicocoele, hernia repair in childhood, tumor/cyst, growth in the scrotum, or removal of a testicle?
☐ Yes ☐ No Please Describe: ______________________

*Have you ever had a disease that can be transmitted by blood including, but not limited to, hepatitis or HIV?
☐ Yes ☐ No Please Describe: ______________________

*Is your partner pregnant?
☐ Yes ☐ No Please Describe: ______________________

*What Method of birth control are you currently using?
☐ Yes ☐ No Please Describe: ______________________

VASECTOMY PREPAREDNESS

*I confirm that I do not want to father any more children in my lifetime. ☐ Yes ☐ No
*I have read the information in the “information” section of this website ☐ Yes ☐ No
*I know I must avoid aspirin, ASA, or any products containing this for 7 days pre-operatively. ☐ Yes ☐ No
*I am aware of the restrictions on physical activity for the week following the vasectomy. ☐ Yes ☐ No

*I fully understand all the questions above and have answered them truthfully. Initials: __________

PAYMENT METHOD

*Payment Type: ______________________
*Credit Card #: ______________________
*Expiration: ______________ *Security Code: ______________
*Name on Card: ______________________
*Billing Address Line 1: ______________________
Billing Address Line 2: ______________________
*City: ______________ *State: ______________ *Zip: ______________

How did you find us? ______________________

I confirm that I am the patient whose name appears in the personal information above and that I am filling this registration for myself and not for my husband or partner.

**Printed Name:* *Date:*

**Signature:* *Date:*