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Evaluation Questionnaire For Vasectomy (Sterilization)

Your response to the items on this Questionnaire will allow us to make a preliminary decision about the proper diagnosis and treatment programs. Please use back of paper for more description of each item if needed.

Name:______________________________ Date:_________________

Please describe in your own words your reasoning for having a vasectomy. Include in this description your current wishes and how it will affect your life. (if more space is needed please use the back of page)

Do you have a stable sexual partner or relationship? Yes_____ No_____
Have you had children with your current partner? Yes_____ No_____
If yes, how many? ________________

Are you and your partner finished having children? Yes_____ No_____
Do you realize that this may be a permanent procedure? Yes_____ No_____
Are you aware that there is a reversal procedure? Yes_____ No_____
Are you aware that reversal success is less than 100%? Yes_____ No_____
Are you aware that there is controversy over an associated risk of prostate cancer and having a vasectomy? Are you aware that the overall weight of the evidence suggests no association? Yes_____ No_____
Have you had any surgery in the pelvic area?
(such as hernia's, pelvic surgery, scrotal surgery) Yes_____ No_____

If yes please list:

Patient Signature_______________________________ Date_____________