Highlands Vasectomy Clinic
Adult History Form

Name (Last, First, M.I)		
Referring Physician:		
Date of Birth:	Home Phone:	Work Phone:

MEDICATION ALLERGIES: (such as penicillin) What happens when you take that medicine:	**OTHER ALLERGIES**: (such as bees/wasps, foods, latex, etc) What happens when you are exposed:

Are you and your partner sure you desire permanent sterilization?

MEDICATIONS: Prescription and Non-Prescription

Please include name of medication, strength and frequency taken:

Have you had any recent use of blood thinners, i.e. aspirin, Motrin, Nuprin, pain or headache medicines , in the last week?

Do you use any street or illicit drugs or medications?

PAST MEDICAL HISTORY

Please describe and give dates of any illnesses, injuries, hospitalizations, and surgeries:

List any mental or psychiatric illness or disease:

List any voiding, urinary or sexual dysfunction issues:

Do you perform regular testicular exams?

Do you currently smoke or chew tobacco?

If no, have you in the past?

If you have used tobacco products in the past or currently:
How many per day? For how long? If former, when did you quit?

Do you sometimes drink alcohol, beer or wine?
If yes: How often? What kind? # of Drinks per week_____

FAMILY HISTORY

Please check any family members who have the following health problems.

	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes						
Glaucoma						
Cancer (List type)						
Heart attack						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Mental Illness						
Suicide						
Other health problems						

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient Name:_____

Patient Signature:_____ Date:_____

How did you hear about us? _____