HORIZON
HEALTH MEN'S CLINIC

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 _____
2. Your age: _____ 3. Education/grade: _____
4. Your occupation _____
5. Your marriage: ☐1st ☐2nd ☐3rd other _____

6. Wife/partner's name_____
7. Her age: _____ 8. Education/grade: _____
9. Her occupation _____
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	☐M ☐F	☐M ☐F	☐M ☐F	☐M ☐F	☐M ☐F	☐M ☐F
Ours / Mine / Hers / Adopted	_____	_____	_____	_____	_____	_____
Living with me: Yes / No	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐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: _____