VASECTOMY REVERSAL QUESTIONAIRE

Patient's Name:_____

Patient's DOB_____

Wife's name_____

Wife's age: _____

Wife's Gynecologist name:_____

Date of marriage:_____

Prior children and ages: patient: _____
wife: _____

Year of vasectomy: _____

Your occupation: _____

Medications currently taking: _____

Allergies:_____

Time frame when reversal is desired to be done?_____

Any questions remaining after review of online information?:_____
_____
_____