<u>Dr. Joshua Green, Center for Vasectomy Reversal and Male Infertility</u>

Patient Registration Form

Please complete <u>all</u> information

Date: ____________________
Last name: ____
First name: ____
Street address: ______________________________________
Apartment #: ________
City: ____________________________ State: _____________
Zip code: ____________

Best phone number to reach you during the day: ____________
Best phone number to reach you in the evening: ____________
Best time to call: _____________________________________
May I leave a message on your answering machine? _________
Email address: _______________________________________

Date of birth (*mm/dd/yyyy*): ____________________________

Marital status: ____
Spouse Name: ____
Spouse date of birth (*mm/dd/yyyy*): _______________________
Spouse phone number: _________________________________

Primary care physician: ________________________________
Physician's office phone number:_________________________

How did you hear about us? *Please check all that apply*:
Internet:
Google: __
Yahoo: __
Bing: __
Other website: __
Doctor referral (*please specify*): _______________________
Friend (*please specify*): ______________________________
Other (*please specify*): _______________________________

Dr. Joshua Green, Center for Vasectomy Reversal and Male Infertility

Name____________________________________ Date________________

History

When was your vasectomy?____

Where was it performed? (in-office, surgery center, military)________________________

Did you have any complications after vasectomy? (Infection, prolonged pain, etc.) _____

____

How many children do you have? ____

Do you have any other urologic or sexual issues other than infertility?________________

____

Did you have any problems conceiving children prior to your vasectomy?_____________

Does your current partner have any expected issues with conception?________________

Has she been evaluated by a gynecologist/ reproductive endocrinologist?_____________

Does she have any biological children? ____

Current Medications & Dose (*include aspirin and OTC medications and supplements*)

____

____

____

Allergies to Medications / Anesthesia

____

____

Dr. Joshua Green, Center for Vasectomy Reversal and Male Infertility

Name____ Date___________________

Past & Present Medical Illnesses (such as high blood pressure, diabetes, heart disease, etc.)

____

____

Prior Surgeries (other than vasectomy)

____

____

Family History

		Relationship to You
Prostate cancer	Yes__ No__	________________________
Infertility	Yes__ No__	________________________
Anesthesia reaction	Yes__ No__	________________________

Social History

How many alcoholic drinks do you have per week? ______________________________
Do you smoke? Yes___ No___
If yes, how many? ____
If stopped, when? ____
How long did you smoke? ____
Have you **ever** been exposed to radiation or chemotherapy? Yes__ No__
Have you **ever** used anabolic steroids? Yes__ No__
Have you **ever** used illicit drugs, including marijuana? Yes__ No__

Do you now, or have you had, problems relating to the following systems?

Vision or hearing loss	Yes__ No__	Diabetes	Yes__ No__
Chest pain or palpitations	Yes__ No__	Depression	Yes__ No__
Shortness of breath	Yes__ No__	Diarrhea	Yes__ No__
Chronic cough	Yes__ No__	Constipation	Yes__ No__
Asthma	Yes__ No__	Weakness	Yes__ No__
Easy bruising or bleeding	Yes__ No__	Headaches	Yes__ No__
Skin rash	Yes__ No__	Back pain	Yes__ No__

Dr. Joshua Green, Center for Vasectomy Reversal and Male Infertility

Name____

Authorization to Release Information

I, _____________________________, authorize Dr. Joshua Green and his employees to speak to and/or release my health care information to the family members or friends listed below:

______________________________ relation to patient___________________________

______________________________ relation to patient___________________________

______________________________ relation to patient___________________________

I agree that messages concerning my care may be left on my phone answering machine or sent to me by email **Yes___ No___**

Patient signature_______________________________Date________________________