Clear Form

Name:	Date of Birth (mm/dd/yyyy):	Date (mm/dd/yyyy):

Welcome, and thank you for the opportunity to participate in your care. Please answer the following questions to help us provide you the best possible care. ***Please do not complete this form on a tablet or mobile device, as the form will not be submitted correctly and will need to be redone on a desktop or laptop computer.*** The responses you provide will determine which informational videos you will be sent. After watching the videos, you will be instructed on how to set up an appointment for further information or pre-schedule your appointment and surgery, if desired. Thank you for your time and decision to seek care at Mayo Clinic.

QUESTION:	RESPONSE:
1. What are some of your reasons for completing this form? Please check all that apply.	☐ Information ☐ Schedule appointment ☐ Schedule vasectomy reversal
2. What is your current age?	
SECTION 1 – Patient Information	
3. Do you have a current sexual partner?	☐ Yes ☐ No
4. How long have you been with your current partner?	years
5. How long has it been since your vasectomy?	years
6. Were there any complications from your vasectomy such as infections, bleeding or repeat procedures?	☐ Yes ☐ No
7. Have you experienced chronic pain following your vasectomy?	☐ Yes ☐ No **(If "No," skip to #8)**
a. If yes, what is the maximum pain you experience? (scale of 0-10, where 0 = no pain, 10 = worst pain imaginable)	NA
8. Have you ever achieved a successful pregnancy (impregnated someone) prior to the vasectomy?	☐ Yes ☐ No **(If "No," skip to #9)**
a. If yes, was the pregnancy with your current partner?	☐ Yes ☐ No
b. If yes, when was the last time you achieved a pregnancy?	years ago
9. Since your vasectomy, have you had an attempted vasectomy reversal?	☐ Yes ☐ No
10. What is your reason for seeking a vasectomy reversal? Check all that apply.	☐ Restore fertility ☐ Improve pain ☐ Other
11. Do you use any substances to help build muscles?	☐ Yes ☐ No **(If "No," skip to #12)**
a. If yes, what substances do you use?	
b. If yes, how many months/years ago did you last use this substance?	months OR years
c. If yes, for how long have you used these substances?	months OR years

12. Have you taken any medications to improve fertility?	☐ Yes ☐ No **(If "No," skip to #13)**
a. If yes, what was the medication?	
13. Have you ever experienced any of the following?	☐ Mumps infection ☐ Scrotal / testicular infections ☐ Testicular trauma, injury or surgery ☐ None of the above
14. Have you ever had surgical repair of hernias?	☐ Yes ☐ No
a. If yes, was mesh placed?	☐ Yes ☐ No
15. Have you ever had any sexually transmitted diseases? Mark all that apply.	☐ No ☐ HIV ☐ Syphilis ☐ Gonorrhea/Chlamydia ☐ Other
SECTION 2 – Partner Information	
16. How old is your partner?	years
17. Has your partner ever been pregnant before?	☐ Yes ☐ No ☐ Unknown **(If "No" or "Unknown," skip to #18)**
a. If yes, how many times has she been pregnant before?	
b. If yes, how many pregnancies resulted in a live birth?	
c. If yes, how long has it been since your partner's most recent pregnancy?	years ago
18. Has your partner ever been evaluated by a fertility specialist?	☐ Yes ☐ No ☐ Unknown
19. Does your partner have any conditions that may reduce her fertility? Mark all that apply.	☐ Abnormal menstrual cycles ☐ Abnormal / missing portions of the uterus, fallopian tubes or ovaries ☐ Polycystic ovarian syndrome ☐ Endometriosis ☐ Other ☐ None ☐ Unknown
20. Has your partner previously been treated with any medications to improve her fertility?	☐ Yes ☐ No ☐ Unknown
SECTION 3 - Testosterone	
21. On a scale of 0-10, how strong is your sexual desire (libido)?	NA
22. Do you have any of the following symptoms (check all that apply)?	☐ Difficulty maintaining healthy weight ☐ Decreased energy ☐ Decreased motivation ☐ Decreased erectile function

	☐ Depression ☐ Memory / concentration problems ☐ Sleepiness
23. Do you have diabetes?	☐ Yes ☐ No ☐ Unknown
24. Have you ever had a testosterone level of less than 300 ng/dl?	☐ Yes ☐ No ☐ Unknown
25. Have you previously used any of the therapies listed to the right?	☐ Gel ☐ Patch ☐ Pill ☐ Injection ☐ Pellets (Testopel)
26. Are you currently receiving testosterone therapy?	☐ Yes ☐ No **(If "No," skip to Section 4)**
a. If yes, what testosterone medicine are you taking?	☐ Gel ☐ Patch ☐ Pill ☐ Injection ☐ Pellets (Testopel)
b. If yes, how long have you taken the testosterone medicine?	Years
c. If yes, did any of the following symptoms improve while receiving testosterone? Select all that apply.	☐ Energy, fatigue ☐ Motivation ☐ Mental capacity ☐ Mood ☐ Muscle / fat ☐ Libido / desire ☐ Erectile function ☐ Other

SECTION 4 – Past Medical History, Substance Use, Family History

Please indicate all conditions that you have been diagnosed with, conditions for which you take medicine or surgeries that you have previously undergone (with dates, if available).

1.	2.	3.	4.	5.	6.
7.	8.	9.	10.	11.	12.

Do you currently smoke?	☐ Yes ☐ No
If you currently or have previously smoked, please indicate the average number of packs per day and number of years.	Packs per day: Total years smoked:
Do you use marijuana?	☐ Yes ☐ No Number of times used per week:
Do you use cocaine, methamphetamines, heroin or any other similar drugs?	☐ Yes ☐ No
Do you currently drink alcohol?	☐ Yes ☐ No Number of drinks per week:

Has anyone in your family had any cancers of the kidney, testicle, bladder or prostate?	☐ Yes ☐ No Details:
Are you currently experiencing any pain? (scale of 0-10, where 0 = no pain, 10 = worst pain imaginable)	0

Please indicate if you are experiencing any of the following symptoms:

☐Fever ☐Sudden loss of vision ☐Inability to smell ☐Chest pain ☐Shortness of breath

☐Vomiting ☐Blood in your urine ☐Rashes ☐Hot flashes ☐Headaches (severe)

☐Swollen glands/lymph nodes ☐Anxiety

END OF SURVEY

To Submit the Survey, Choose One of the Following Options:

Option 1:

- Click "Save File" Button [Save File]
- Select Location to Save File on Your Computer
- Open a New Email and Attach the Saved File
- Send the email to:

VasectomyReversal@mayo.edu

Option 2:

- Click "Submit" Button
- Click "Default email application (Mail)"
- Follow Subsequent Prompts to Send Message

[Submit]