

Andrology and Microsurgery
Dr. Petsch
Vasectomy Reversal Patient Data

Personal data:	
Family name	
First name	
Date of birth; age	
Phonenumber	Mobile: _____ Home: _____
Street, No.	
City, Postal Code, Country	
Email	

Children?	<input type="radio"/> yes ____ number of children <input type="radio"/> no
Infertility	<input type="radio"/> vasectomy _____ years ago
Vasectomy location:	<input type="radio"/> Scrotum <input type="radio"/> inguinal region
Other reasons for infertility:	<input type="radio"/> after epididymitis / orchitis <input type="radio"/> other reasons: _____
Inguinal hernia repair?	<input type="radio"/> no <input type="radio"/> right <input type="radio"/> left <input type="radio"/> on both sides
History of severe diseases?	
Surgeries:	
Allergy:	<input type="radio"/> no <input type="radio"/> yes: _____
Alkohol:	<input type="radio"/> no <input type="radio"/> rarely <input type="radio"/> occasional <input type="radio"/> regular
Smoking:	<input type="radio"/> Non-Smoker <input type="radio"/> Smoker: _____ cigarettes per day

Female	
Name, First name	
Age	
Children together?	<input type="radio"/> no <input type="radio"/> yes. Number _____
Previous pregnancies	<input type="radio"/> no <input type="radio"/> abortion <input type="radio"/> birth; number _____
History of severe diseases?	

