

The Microsurgical Center
John S. Gatewood, M.D.
1-888-702-BABY (2229)/Fax (941) 739-8528
PRE-SURGICAL/ANESTHESIA QUESTIONNAIRE

Name _____ Date _____

Age _____ Weight _____ Height _____

Date of Surgery _____

When was your original vasectomy performed _____

Family Physician _____ Phone _____

Medical Specialist _____ Phone _____

Major Illnesses _____

Current Medications _____

Do you take aspirin or aspirin products _____
(All aspirin products must be stopped 3 weeks prior to surgery)

Allergies _____

Herbal Supplements _____
(All dietary/herbal supplements must be stopped 2 weeks prior to surgery)

Prior Operations & Any Complications _____

(Provide approximate dates, for hernia repairs tell us what side, if mesh was used and if it was done by laproscopic or conventional technique)

Have you had sperm retrieval or aspiration? ___ Yes ___ No From testicle or epididymus?(circle one)
If yes, which side ___ Right ___ Left ___ Both Date procedure done _____
Was an incision used or was it done with a needle only? _____ Please provide records.

Have you or a blood relative ever had a problem with anesthetic? ___ Yes ___ No
If yes, please explain _____

Are you allergic to local anesthesia, any medications, latex, iodine or tape? ___ Yes ___ No
If yes, please explain _____

Do you smoke? ___ Yes ___ No If yes, how much? _____

Do you use alcohol? ___ Yes ___ No ___ Occasional

Have you ever been treated for drug or alcohol abuse? ___ Yes ___ No
If yes, please explain _____

Please answer **Yes** or **No** to the following questions. If you answer "Yes" to any, please provide detailed information about the condition and if you are currently being treated.

- Blood Pressure Problems Yes No
- Juvenile Diabetes (Type 1) Yes No
- Adult Diabetes (Type 2) Yes No
- Heart Problems/Chest Pain Yes No
- Heart Disease Yes No
- Irregular Heart Beat Yes No
- Deep Venous Thrombosis Yes No
(Blood clots in lower extremities or pelvis)
- Pulmonary Embolism Yes No
(Blood clots in lungs)
- Phlebitis Yes No
(Inflammation of veins in lower extremities)
- Hepatitis (specify type) Yes No
- Bleeding Problems Yes No
- Epilepsy or Seizures Yes No
- Severe Headaches Yes No
- Arthritis Yes No
- Asthma/Breathing Problems Yes No
Childhood or Adult
- Back Problems/Pain Yes No
- Blood Transfusion Yes No
- Broken Bones Yes No
Any remaining pins or plates Yes No
- Cancer Yes No
- Drug Abuse Yes No
- Glaucoma Yes No
- Hiatal Hernia Yes No
- Psychiatric Treatment Yes No
- Pneumonia Yes No
- Shortness of Breath Yes No
- Stomach Pain Yes No
- Stomach Ulcers Yes No
- Sleep Apnea Yes No
(Tendency to quit breathing when you fall asleep)
- Gastro-Esophageal Reflux Yes No
(Sometimes called "GERD" is the regurgitation of stomach contents up the esophagus)
- Tuberculosis Yes No
- Unexplained weight loss Yes No
- Number of children fathered _____

Patient Signature _____ Date _____

Reviewed by _____ Date _____

John S. Gatewood, MD

***Please complete and return for Dr. Gatewood to review as soon as possible. Thank you. ***
If you have any questions, please contact the office.

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