Texas Vasectomy Center
Darren M. Chapman, MD PLLC
10970 Shadow Creek Parkway, Suite 255 | Pearland, TX 77584
(832) 753-4300 | Fax (832) 753-4301

New Patient Paperwork

Please complete all applicable sections before your appointment.

PATIENT INFORMATION

Today's date: _____ **Referring physician:** _____

Last name: _____ **First name / MI:** _____

Street address: _____ **City / State / ZIP:** _____

Birth date / Age: _____ **Cell phone:** _____

Email: _____ **Preferred language:** _____

CONTACT, PHARMACY, AND EMPLOYMENT

Home phone: _____ **Occupation:** _____

Employer: _____ **Employer phone:** _____

Pharmacy name: _____ **Pharmacy phone:** _____

INSURANCE INFORMATION

Primary insurance: _____ **Name of insured / DOB:** _____

Policy number: _____ **Group number:** _____

Secondary insurance: _____ **Name of insured / DOB:** _____

Policy number: _____ **Group number:** _____

RESPONSIBLE PARTY AND EMERGENCY CONTACT

Person responsible for bill: _____ **Relationship to patient:** _____

Address if different: _____ **Phone:** _____

Emergency contact: _____ **Relationship:** _____

Cell phone: _____ **Other phone:** _____

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ALLERGIES AND MEDICAL HISTORY

Allergies (list all, or write NONE): _____

Other important reactions or sensitivities: _____

Heart / Blood

☐ Anemia
☐ Angina / chest pain
☐ Atrial fibrillation
☐ Bleeding disorder
☐ Blood clots / DVT
☐ Congestive heart failure
☐ Coronary artery disease
☐ Heart attack
☐ Heart murmur
☐ Heart valve problem / replacement
☐ High blood pressure
☐ Irregular heartbeat
☐ Stroke

Endocrine / General

☐ Diabetes
☐ Gout
☐ High cholesterol
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Sleep apnea
☐ Hernia

GI / Liver

☐ Colitis
☐ Crohn's disease
☐ GERD / acid reflux
☐ Hepatitis
☐ Inflammatory bowel disease
☐ Ulcerative colitis
☐ Peptic ulcer
☐ Gallstones

Genitourinary

☐ Bladder infection / UTI
☐ Blood in urine
☐ Chronic kidney disease
☐ Erectile dysfunction
☐ Kidney infection
☐ Kidney stones
☐ Orchitis / testicle infection
☐ Undescended testicle
☐ Prior vasectomy or reversal

Neurologic / Psychiatric

☐ Anxiety
☐ Bipolar disorder
☐ Depression
☐ Epilepsy / seizures
☐ Migraine
☐ Multiple sclerosis
☐ Parkinson's disease
☐ Spinal cord injury

Respiratory

☐ Asthma
☐ Bronchitis
☐ COPD / emphysema
☐ Pneumonia
☐ Pulmonary embolism
☐ Tuberculosis

Cancer History

☐ Bladder cancer
☐ Colon cancer
☐ Kidney cancer
☐ Lung cancer
☐ Lymphoma
☐ Melanoma
☐ Prostate cancer
☐ Testicular cancer

Other

☐ Arthritis
☐ Back pain
☐ HIV / AIDS
☐ Mumps
☐ Other significant condition

Initial here if you have no medical problems: _____

Other diseases or conditions: _____

_____

_____

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PAST SURGICAL HISTORY

Heart / Vascular

☐ Angioplasty / stent
☐ Aortic aneurysm repair
☐ CABG / bypass
☐ Carotid surgery
☐ Heart transplant
☐ Pacemaker
☐ Artificial heart valve

Abdominal / GI

☐ Appendectomy
☐ Bowel / colon resection
☐ Gallbladder removal
☐ Hernia repair
☐ Weight-loss surgery
☐ Other abdominal surgery

Urologic / Genital

☐ Bladder surgery
☐ Circumcision
☐ Cystoscopy
☐ Epididymectomy
☐ Hydrocelectomy
☐ Kidney stone surgery
☐ Kidney removal
☐ Kidney transplant
☐ Penile implant
☐ Prostate biopsy
☐ Prostate surgery
☐ Spermatocelectomy
☐ Testicle removal
☐ Urethral dilation
☐ Ureteral stent
☐ Varicocelectomy
☐ Vasectomy
☐ Vasectomy reversal

Other Surgery

☐ Back / spine surgery
☐ Eye surgery
☐ Hand / wrist surgery
☐ Hip surgery
☐ Knee surgery
☐ Neck surgery
☐ Shoulder surgery
☐ Skin cancer surgery
☐ Thyroid surgery
☐ Tonsil / sinus surgery

For each checked procedure, list the year and any important details:

_____

_____

_____

_____

_____

Initial here if you have had no surgeries: _____

FAMILY AND SOCIAL HISTORY

Family history of prostate cancer: _____

Family history of testicular cancer: _____

Family history of kidney / bladder cancer: _____

Family history of bleeding problems: _____

Alcohol use (none / occasional / daily): _____

Tobacco use: _____

If former smoker, quit date: _____

Caffeine per day: _____

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CURRENT MEDICATIONS

Are you taking aspirin or any blood thinner (for example: clopidogrel/Plavix, warfarin/Coumadin, apixaban/Eliquis, rivaroxaban/Xarelto)? Yes / No

Medication	Dose	How often / instructions

REVIEW OF SYSTEMS

Check any symptoms you are currently experiencing. Leave blank if none apply.

General
☐ Fever / chills
☐ Unexplained weight loss
☐ Weakness / fatigue

Heart / Lungs
☐ Chest pain
☐ Palpitations
☐ Shortness of breath
☐ Wheezing
☐ Swelling of legs

GI
☐ Abdominal pain
☐ Blood in stool
☐ Constipation
☐ Diarrhea
☐ Nausea / vomiting

Urinary / Genital
☐ Painful urination
☐ Blood in urine
☐ Urinary frequency
☐ Urinary hesitancy
☐ Incontinence
☐ Scrotal or testicular pain / swelling

Neurologic
☐ Dizziness
☐ Headache
☐ Numbness / tingling
☐ Seizures

Skin / Blood
☐ Rash / itching
☐ Unusual bruising
☐ Bleeding problems

Emotional Health
☐ Anxiety
☐ Depression
☐ Other concern

PATIENT CERTIFICATION

I certify that the information provided in this packet is complete and accurate to the best of my knowledge. I understand that I should tell Texas Vasectomy Center about any change in my health, medications, allergies, or insurance information.

Patient name _____ Signature _____ Date _____