Family Surgical Solutions, L.L.C.

Dr. Dennis Streeter, D.O., F.A.A.O.S.
8127 Merrillville Rd. Ste. 3
Merrillville, IN 46410

Please provide the necessary information to help determine if you are a candidate for tubal ligation reversal or vasectomy reversal. Please note that this information is strictly held confidential.

Date: _____ **Full Name:**_____

Maiden Mane (Tubal Reversal Candidates ONLY) _____

Address:_____

Phone: _____ **Cell Phone:**_____ **Email Address:**_____

Date od Birth (____/____/____) Age_____ **Social Security#** _____

Is this for **Tubal Ligation Reversal** ( ) **Vasectomy Reversal** ( )

Please list any Medical Problems:_____

_____

Please list any Past Surgeries (year) :_____

_____

_____

Please list any medications you are on (and indicate if taking any blood thinners such as aspirin. Plavix or Coumadin) _____

_____

_____

Please list ANY AND ALL Allergies (including latex and food allergies) _____

_____

Do you Smoke **YES ( ) NO ( )** **Height:** _____ **Weight:** _____

What is your spouse name and age _____

Please list the ages and sex of your children: _____

_____

How did you hear of Dr. Streeter? Web site_____ Referral from friend or family _____

NOTE: Please submit a copy of your Operative Report and Pathology Report if Tubal ligation performed or send Operative report only if Vasectomy performed in past.

fax: 219-791-9787 to expedite the scheduling of your procedure or email to doctor@drdennisstreeter.com