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 Name (Tubal Reversal Candidates ONLY) _____

Address: _____

Phone: _____ Cell Phone: _____ Email Address: _____

Date of Birth: (___/___/___) Age: _____ Social Security #_____

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

Please list any Medical Problems: _____

_____

Please list any Past Surgeries: _____

_____

_____

Please list any medications you are one (indicate if you are 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's name and age?

_____

What is your spouse's cell phone?

_____

Please list the ages and gender of your children:

_____

NOTE: Please submit a copy of your Operative Report and Pathology Report for Tubal Ligation candidates

To expedite the scheduling of your procedure, fax all paperwork to (219-791-9787) or email us at drstreeter01@gmail.com