Urology of Indiana

New Patient Survey For Patients Visiting The Men's Health Center for Fertility

Clinic - (317) 564-5104 | Surgery Scheduling - (317) 807-0159

Name: _____

Date of Birth: _____

1) What is your partner's name, age, and date of birth (DOB)?

Partner's Name and DOB: _____

2) What best describes you and your partner's relationship? How long have you been together in this capacity? (ex. married for 3 years)

Relationship and duration: _____

3) How long have you and your partner been trying to achieve pregnancy? (Please write a number and circle years or months)

__ years / months

4) What do you and your partner do for a living?

- _____

5) Have either you OR your partner ever been involved in any prior pregnancies?

Yes / No

If yes, please explain: _____

6) Is your partner here with you today?

Yes / No

7) Have you ever had a semen analysis? (test to assess sperm count & concentration)

Yes / No

If yes, where was it performed? _____

Please complete all 5 pages of this document. Thank you.

8) Do you recall ever being exposed to any chemicals, chemotherapy medications, radiation, or other toxins?

Yes / No

If yes, please explain: _____

9) Have you ever been diagnosed with any sort of urinary tract, testicular, or prostate infection? This includes any sort of sexually transmitted infections.

Yes / No

If yes, please explain: _____

10) Have you ever experienced any sort of trauma or surgery to the testicles or groin? (this includes any hernia repairs in the groin)

Yes / No

If yes, please explain: _____

11) Have you ever been diagnosed any of the following conditions: varicocele, testicular torsion, undescended testicle, or mumps?

Yes / No

If yes, please explain: _____

12) Do you have any known history of infertility in your family?

Yes / No

13) Have you ever taken testosterone, SARMs, or other anabolic steroid products?

Yes / No

If yes, please explain: _____

14) Have you had any recent high fevers (over 101.5 deg F) or exposure to 'wet heat' such as saunas or hot tubs?

Yes / No

If yes, please explain: _____

15) Do you currently use any tobacco or nicotine containing products? If yes, please list the product, the amount, and duration of use. (ex. Cigarettes, 1 pack per day for 20 years)

Yes / No

Product / amount / duration? _____

16) If do not currently use any tobacco or nicotine containing products, but used to, please list what you used to use, the amount, the duration, and when you stopped using. (ex. Cigarettes, 1 pack per day for 20 years, Quit 5 years ago)

Product / amount / duration? _____

17) How many alcoholic beverages do you think you have in an average week? (ex. 4 beers a week)

Amount: _____

18) Do you use any other substances that don't come from physician? (ex. marijuana)

Yes / No

If yes, please list: _____

19) Do you take any sort of long-term medications or supplements?

Yes / No

If yes, please explain: _____

20) Does your partner have regular monthly cycles?

Yes / No

If no, please explain: _____

21) Does your partner have any long-term medical conditions or take any medications?

Yes / No

If yes, please explain: _____

22) Has your partner ever taken any form of birth control?

Yes / No

If yes, please explain and detail when this was stopped:

- _____

23) Has your partner been evaluated by a gynecologist or a reproductive endocrinologist? (A reproductive endocrinologist is a gynecologist who has completed specialty training in female fertility and performs in-vitro fertilization)

Yes / No

If yes, please list her physician's name:_____

If yes, please list any testing that has been performed and findings. (example, an dye test known as an HSG showed fallopian tube blockage or an ultrasound showed PCOS or endometriosis).

- _____
- _____

24) Have you and your partner tried IUI or IVF in the past?

Yes / No

If yes, please explain: _____

25) Have you and your partner been timing intercourse with ovulation?

Yes / No

If yes, please explain what you've been using to help time cycles (example, an app or urine ovulatory predictor kits aka OPKs or pee strips):

- _____

26) Do you and your partner use any lubrication with sex?

Yes / No

If yes, please list brand: _____

27) Have you experienced any problems with your erections, ejaculation, or other issues in the bedroom while trying to get pregnant?

Yes / No