Urology of Indiana

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

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

Name: _____

Age and Date of Birth: _____

1) Have you ever had your testosterone checked before?

Yes / No

If yes, when was it checked and who checked it? Please list the physician/clinic name if known. Please list the level if known.

Name: _____

2) What symptoms prompted you, or are currently prompting you, to have your testosterone levels checked? Please circle all that apply.

- Low Sex Drive
- Erectile Dysfunction
- Low Energy
- Decreased Muscle Mass
- Increased Fat Gain
- Brain Fog / Difficulty Focusing

Other symptoms: _____

3) How long have you been experiencing these symptoms? (Please write a number and circle years or months)

__ years / months

4) Do you currently have any children?

Yes / No

If yes, how many? ___

Please complete all 4 pages of this document. Thank you.

5) Do you want to have any more children in the future?

Yes / No

6) Long term testosterone usage may cause testicular shrinkage and make it more difficult for the body to make it's own testosterone. These effects can be reduced with a weekly injection of a different medication known as HCG designed to stimulate the testicles. This has an approximate monthly out-of-pocket cost of $60. Is this something you would be interested in?

Yes / No

7) Have you ever experienced breast development / tenderness (also known as gynecomastia) or marked nipple sensitivity?

Yes / No

8) Have you, or anyone in your family, ever been diagnosed with prostate cancer?

Yes / No

If yes, who and at what age was their diagnosis? What was the outcome of this?

_____

9) Do you current take any long-term medications from a physician?

Yes / No

If yes, please list: _____

_____

_____

10) 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? _____

11) 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? _____

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

Amount: _____

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

Yes / No

If yes, please list: _____

14) Have you ever taken testosterone prescribed by a physician?

Yes / No

If yes, please list type and dose:_____

Are you currently taking this? How long have you been taking it?

_____

15) Have you ever taken testosterone or other anabolic steroids NOT prescribed by a physician?

Yes / No

If yes, please list type and dose:_____

Are you currently taking this? How long have you been taking it?

_____

_____

16) What do you do for a living? If retired, what did you used to do?

- _____