



**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? \_\_\_\_\_

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



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## SURGERY CANCELLATION & NO-SHOW POLICY

Thank you for choosing the **Men’s Health Center at Urology of Indiana** for your care. As part of our standard intake process, we ask all patients to review and acknowledge the surgical scheduling policy below. **Signing this form does not mean that surgery has been recommended or that a procedure is being scheduled.** It simply ensures that you are aware of our office policy in the event that a surgical procedure is recommended and scheduled in the future.

We understand that unforeseen circumstances—such as family emergencies or personal obligations—may occasionally require a patient to cancel or reschedule a planned surgery. If that situation arises, we respectfully ask that you provide as much advance notice as possible so that we may offer the surgical time to another patient in need of care.

To schedule, cancel or reschedule a surgery, please contact our office at: **(317) 807-0159**

### PLEASE REVIEW THE FOLLOWING POLICY:

1. All surgical cancellations or reschedule requests must be made at least four (4) weeks (28 calendar days) prior to the scheduled surgery date.
2. Any cancellation made less than four (4) weeks before the scheduled surgery date will be documented as a policy violation and may be subject to a **\$500.00 cancellation fee**.
3. If you do not appear for your scheduled surgery without any prior notification, this will be documented as a “No-Show” and will also be subject to the **\$500.00 fee**.
4. After a first policy violation, you will receive a phone call or written notice as a courtesy reminder of this policy. Please note that repeated violations may limit our ability to schedule future procedures on your behalf.
5. Chronic no-shows or repeated late cancellations may result in dismissal from the surgical schedule and potential termination of the patient–provider relationship.

By signing below, I acknowledge that I have read and understand the Urology of Indiana **“Surgery Cancellation & No-Show Policy.”** I understand that this policy will apply if a surgical procedure is scheduled for me at any point during my care with this practice.

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**Patient Name** **Date of Birth** **Date**

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**Patient Signature (or Parent/Guardian if Minor)** **Date**

*Thank you for your understanding and cooperation as we strive to best serve the needs of our patients.*