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 5 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?

- _______________________________________

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

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.

____

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

____

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.

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